CCH Health Care Compliance LETTER

Volume 9, Issue 21 health.cch.com October 16, 2006

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Parts B, D drug benefits high priority in FY 2007 work plan

by Stacey Fahrner, J.D., M.P.H., Contributing Editor

As part of the strategic plan for fiscal year (FY) 2007, the Office of Inspector General (OIG) will continue to focus on vulnerabilities in the Medicare Part B and Part D drug benefits as it did in 2006. The OIG will work to identify and investigate legal schemes to market, obtain, use, and distribute prescription drugs.

Part B. According to the work plan, the OIG will evaluate drug manufacturers' methodologies for computing average sales price (ASP), review Part B reimbursement methodology, and review the adequacy of Part B payments under the ASP methodology.

Part D. The OIG's efforts regarding Part D will focus on the administration of the benefit. For example, drug access through prior authorizations and exceptions will be examined as well as trends in drug prices. The OIG also will examine beneficiary access to retail pharmacies in rural areas and state contribution towards dual Medicare and Medicaid eligible beneficiaries. In addition, the OIG will evaluate the coordination of Parts D and B to avoid duplicate payment and conduct Parts B and D pricing comparisons.

Fraud and abuse. In FY 2007, the OIG plans to increase its attention on quality of care issues for beneficiaries residing in nursing homes. Specifically, the OIG is concerned that Medicare and Medicaid are billed improperly for medically unnecessary services and services not rendered as prescribed. In addition, the OIG will be involved with assessing state false claims laws under the requirements of the Deficit Reduction Act of 2005, which take effect in January 2007.

Other priorities. The prospective payment systems are high priorities for 2007. According to the work plan, the OIG will evaluate the methodology used to update inpatient hospital capital payments, adjustments for graduate medical education, nursing and allied health education payments, inpatient prospective payment system (PPS) wage indices, outlier payments to inpatient rehabilitation facilities, and payments under the long-term care PPS. Medical appropriateness and coding of diagnosis related groups (DRGs) will be evaluated to identify providers who exhibit high or unusual patterns for selected DRGs. Finally, the OIG will assess CMS oversight of physician-owned specialty hospitals with special attention focused on policies relating to staffing requirements. ■

OIG Work Plan FY 2007, Oct. 3, 2006.

Wolters Kluwer Law & Business

Hospital tax-exemption revoked for insufficient charity care

by Stacey Fahrner, J.D., M.P.H., Contributing Editor

The tax exemption of an Illinois acute care hospital, Provena Covenant Medical Center (Covenant), was revoked based on the "insufficient" amount of charity care provided according to a written decision by Brian Hamer, the director of the Illinois Department of Revenue on September 29, 2006. Although the decision was based on Illinois property tax exemption laws, it has been monitored closely by the tax-exempt community nationally given the recent scrutiny of charity care and billing practices of not for profit hospitals in every state.

Illinois charitable organizations. Under Illinois law, an organization can qualify for property tax exemption when the primary purpose of the organization is charitable. 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 Convenant's charitable activities. Specifically, Covenant admitted that its 2002 revenues exceeded $113 million and its charitable activities cost only $831,724, or approximately 0.7 percent of its total revenue. In contrast, the value of the 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, or the exchange of services for revenue, which supported the conclusion that the property was not used "exclusively" for charitable purposes as required by state law.

Charity care policy. Hamer also pointed out inconsistencies with the application of Covenant's charity care policy. Many of the major hospital services were contracted out to third-party for-profit providers. According to Hamer, Covenant provided no evidence to quantify the amount of charity care provided to its patients by these third-parties or evidence to suggest that the third-party providers were complying with Covenant's charity care policy. Hamer also noted that the charity care policy itself, which offered a percentage reduction based on the patient's income, was insufficient because it failed to consider the financial burden of the medical services rendered. Moreover, Provena, Covenant's parent company, referred patients with unpaid charges to collection agencies even when a portion of the charges had been reduced pursuant to the charity care policy; a practice previously determined to be inconsistent with charitable activities. Finally, Hamer attacked Covenant's failure to meaningfully publicize its charity care policies.

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 from that year. Illinois courts, however, consistently have rejected the idea that Medicare and Medicaid unreimbursed costs represent charity care. Furthermore, the record showed that Covenant attempted to collect those charges from patients. Covenant also argued that it made many contributions to improve the well-being of the community. According to Hamer, property tax exemptions do not turn on those contributions.

Provena's response. Provena Covenant hospital immediately announced plans to appeal the ruling. William T. Foley, President and chief executive officer, stated that the decision was "outrageous, unsupported by legal precedent, or the facts we provided. The state's ruling flies in the face of our own charitable mission and challenges every Illinois hospital's ability to continue serving the poor and uninsured."

Since the original recommendation in 2003, Covenant contends that it has paid over $4.8 million in property taxes. Covenant also argues that, according it its figures, it provides over $21 million annually in charitable benefits to the community. "This is a crisis for Provena Covenant and a national crisis for nonprofit hospitals. Community hospitals that care for the uninsured, Medicaid-insured and indigent populations are left with little financial resources to pay for property tax," said Foley.

Ken Robbins, President of the Illinois Hospital Association defended Covenant's position and attacked the ruling, which he described as disturbing. "Imposing new tax burdens on hospitals such as Provena Covenant will only force them to reduce services and increase health care costs, thereby jeopardizing access to quality health care services as well as the financial viability of the hospital," he said. ■

Illinois Department of Revenue v. Provena Covenant Medical Center, No. 04-PT,-0014, Sept.29, 2006, Provena Covenant Press Release, Sept. 29, 2006.

CCH Health Care Compliance Letter

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CCH Health Care Compliance Letter is published 24 times a year by CCH, a Wolters Kluwer business, 4025 W. Peterson Avenue, Chicago, IL, 60646. Subscription rate is $305 per year. First-class postage paid at Chicago, Illinois, and at additional mailing offices. POSTMASTER: SEND ADDRESS CHANGES TO *CCH Health Care Compliance Letter*, 4025 W. PETERSON AVENUE, CHICAGO, IL 60646. Printed in U.S.A.

Pay-for-performance aligns incentives, IOM finds

by Jenny Burke, J.D., Contributing Editor

Fundamental changes in approaches to health care payment are necessary to efficiently deliver high-quality care, according a study released by the Institute of Medicine (IOM). The study, which found that current payment systems are not well-aligned with efforts to achieve quality, promotes rewards given to providers who foster quality care.

Over $300 billion in health care benefits are provided annually to approximately 42 million Americans. Reimbursement rates to participating providers do not vary with the quality of care patients receive. Not only does the system fail to pay for preventive services such as patient education, but coordination of care is unsupported and no incentives are offered to improve patients' overall health status, according to the report.

Objectives. The IOM believes that to increase the likelihood of participation by as many health care providers as possible, the program should reward those who improve their performance significantly as well as those who meet or exceed designated thresholds of excellence. As providers increasingly make improvements, the fraction of rewards for excellence will grow; therefore, the standards for achieving improvements should be raised appropriately.

IOM touts pay-for-performance as an opportunity to improve not only the overall quality of care for Medicare enrollees, but also the care provided to other populations. The objectives of pay-for-performance are to: (1) encourage the most rapid feasibly performance improvement by all providers; (2) support innovation and constructive change throughout the health care system to achieve clinical quality improvements, patient-centered care, and efficient use of health resources; and (3) promote better outcomes of care, especially through coordination of care across provider settings and time, especially in the treatment of chronic disease.

IOM promoted the use of a gradual implementation, which would enable officials to assess the program along the way, adapt to knowledge gained, and monitor for unintended negative effects. According to the IOM, Congress should determine decreases in the amounts of Medicare base payments, to create a pool of funds for bonus payments.

It recommended that the percentage be sufficient to create rewards large enough to motivate health care providers' participation. Because physician fees are scheduled to decline over the next few years, IOM suggested that Congress appropriate new funds to ensure that the reward pool is sufficient. Over time, however, the reward pool could be sustained through savings generated by improved efficiency and cost-reducing reforms. ■

CCH Chicago Bureau, Sept. 27, 2006.

Weaknesses found in security of CMS transmissions

by Geraldine Szuberla, J.D., Contributing Editor

Numerous vulnerabilities existed in the CMS communication and data transmission network used by Medicare providers and fiscal contractors, according to an investigation conducted by the Government Accountability Office (GAO). CMS responded by implementing corrective actions for reported weaknesses in security policies and standards.

CMS relies on a contractor-owned and operated network from which it purchases networking services to provide connectivity to its business partners and support communication and data transmission. The communication network transmits Medicare claims data containing personally identifiable information and medical information such as a patient's diagnosis. The communication network also transmits payment information.

The areas of vulnerability in the data network as identified by GAO included: (1) user identification and authentication, (2) user authorization, (3) system boundary protection, (4) cryptography, and (5) auditing and monitoring of security-related events. There also were weaknesses in controls designed to ensure that secure configurations would be implemented on network devices and incompatible duties would be sufficiently segregated. A key reason for these weaknesses was that CMS did not always ensure that its network contractor effectively implemented electronic access controls designed to prevent, limit, and detect unauthorized access to sensitive computing resources and devices used to support the communication network. ■

GAO Report, No. GAO-06-750, Aug. 2006, Health Care Compliance Reporter, ¶550,071.

Community benefit revisited: The IRS and Congress take a closer look

by Cynthia F. Reaves, J.D., Contributing Editor

In May 2006, the IRS sent a "Compliance Check Questionnaire," (Form 13790) to several hundred hospitals nationwide seeking information about how these hospitals comply with the community benefit standard of Revenue Ruling 69-545. Unlike the earlier compensation review initiatives that were distributed to a range of nonprofit entities, the compliance check was targeted exclusively to nonprofit hospitals and health systems. The Questionnaire reviewed operations, governance and compensation issues raised in the activities of tax-exempt hospitals. Unlike an audit a "compliance check" is merely a data-gathering device, but the information generated by a compliance check can lead to an audit. This article revisits the community benefit requirements imposed upon tax-exempt hospitals through the lens of the recent IRS and congressional initiatives to review closely the operations of these entities.

The release of the Questionnaire, along with the earlier compensation audits undertaken by the IRS, focused congressional interest on the activities of nonprofit hospitals. On September 13, 2006, the Senate Finance Committee focused on the community benefit standard of tax-exempt hospitals by conducting hearings which focused upon the operations of these entities. The heightened scrutiny tax-exempt hospitals are undergoing underscores the critical need for these organizations to not only engage in, but accurately and fully document the charitable and other benefits that they provide to their communities.

Origins of the "Community Benefit" Standard

Although the Questionnaire is a recent IRS compliance tool, the subject matter of the Questionnaire is based upon formal guidance the IRS first issued in 1969 and still relies on today as the basic foundation upon which to determine exempt organization status for nonprofit hospitals. In 1969, the IRS issued *Revenue Ruling 69-545* which established the community benefit standard and identified several criteria important to tax-exempt status under section 501(c)(3). Specifically, the ruling prescribed that tax-exempt hospitals have: (1) community-based boards without financial interests in the institution, (2) a full-time emergency room open to all without regard to ability to pay, (3) an open medical staff policy, (4) treatment of Medicare and Medicaid patients without discrimination, and (5) an appropriate mission-related use of net earnings. Over the years, these provisions have been reviewed and clarified, but the requirements remain essentially intact.[1] The IRS has employed an overall "facts and circumstances" approach in determining whether an entity qualifies for tax-exempt status under section 501(c)(3).

In addition to the community benefit requirements, nonprofit hospitals must also comply with other 501(c)(3) requirements such as operating for the benefit of the community and avoiding individual inurement and excessive private benefit, political campaign involvement and excessive lobbying. Further, in *General Counsel Memorandum 39862*,[2] the IRS identified other factors as indicia of community benefit, in particular, these factors include: (1) the creation of a new provider of healthcare services; (2) expansion of community health resources; (3) improvement of treatment modalities; (4) reduction in health care costs; and (5) improvement in patient convenience and access to physicians. Many commentators have correctly noted that the community benefit standard established in Rev. Rul. 69-545 imposes no charity care requirements upon tax-exempt hospitals, other than in the requirement that emergency rooms be open and available to all regardless of ability to pay. Indeed, in Rev. Rul. 69-545 the IRS finds as exempt, a hospital that referred all non-emergency charity care cases to a nearby public hospital.[3]

A Look at the Questionnaire (IRS Form 13790)

The principal focus of the Questionnaire is a series of approximately 80 questions divided into three major categories. These questions seek information about what community benefits hospitals provide and how they provide them. Although charity

care is a key area of inquiry, the Questionnaire also seeks information regarding other areas including, patient demographics, governing board composition, uncompensated care, billing and collection practices, and community outreach programs. Failure to respond to the Questionnaire, or the submission of unsatisfactory or questionable responses, could lead to an audit.

The Questionnaire is divided into three components. Part I asks for basic information about the reporting organization. Part II focuses on various community benefit activities and the governance of the organization. Part III inquires into the compensation practices of the organization. Charity care is the primary focus of the Questionnaire with over seventy questions in Part II of the form dedicated to this topic. In this regard, the community benefit questions set forth in Part II address the following: (1) coverage and care protocols based upon patient demographics, including any instances of the exempt hospital denying medical care for patients; (2) the operation of the hospital's emergency room; (3) the composition and meeting protocols of the organization's governing board; (4) the dictates of and requirements attendant the granting of medical staff privileges (and whether there is an open-staff standard); (5) medical research activities (including the source of funding and access to the results); (6) medical education and training programs; (7) the amount of "uncompensated care" which the hospital provides, which includes an examination of how the hospital classifies bad debt; (8) billing and collection practices; and (9) community outreach programs.

When compared to IRS Form 990, which provides exempt organizations with the opportunity to broadcast their activities that benefit the community to the interested public, the Questionnaire is much more comprehensive and imposing. In this regard, although the Questionnaire was distributed to specific hospitals, other hospitals would do well to review the inquiries and formulate responses to them as part of an internal due diligence process. For this reason, it would be instructive to understand some of the underlying issues upon which the various community benefit and board governance inquiries are based:

- *Patient Demographics:* Here, the IRS is concerned with whether an exempt hospital provides non-emergency services to all without regard to ability to pay, such as Medicare and Medicaid enrollees. Hospitals should review their patient demographic mix and document the care given to various groups, including care to uninsured patients.
- *Emergency Room:* While the operation of an emergency room is not an absolute requirement for tax-exempt status where adequate emergency room care is available in a particular community, hospitals that operate emergency rooms should document treatment outcomes. The Questionnaire makes inquiries into patients who were "denied" treatment. Consequently, it would be prudent for exempt hospitals to review their emergency room policies and procedures and document the rationale for emergency room treatment decisions.
- *Governing Board:* In recent years, the IRS has provided great insight into their concerns with respect to exempt organization governing boards. The governing board should be comprised of independent community leaders. Further, as "disqualified persons" under Code section 4958, the IRS will want to determine whether the Board has adopted and abides by a substantial conflicts of interest policy.
- *Medical Staff Privileges.* Rev. Rul. 69-545 required an exempt hospital to have an "open" medical staff. Hospitals should make sure that they allow physician participation from throughout the community on the medical staff.
- *Medical Research.* The Questionnaire raises over nine questions with respect to medical research. In essence, the IRS is interested in the funding, public access to results, medical trials and sources of funding of medical research.
- *Medical Training.* The IRS has determined that a medical training program is indicia of an exempt hospital's effort to further its exempt purposes. Hospitals should track the amount and extent of medical education and the source of funding for such programs.
- *Uncompensated Care.* How a hospital classifies uncompensated care has been the subject of substantial IRS interest. Importantly, a hospital should focus on how it determines what constitutes uncompensated care and how it reports its uncompensated care.
- *Billing and Collection Practices.* In recent years, patient class action suits have resulted in increased attention to billing and collection practices. The Questionnaire sets forth several questions relating to the billing cycle, collection practices, settlement options and charge structures for hospitals. Hospitals should assess their practices in light of the current focus on these activities.
- *Community Outreach.* The presence of community programs is indicia of fulfilling a community benefit obligation for purposes of exemption. The Questionnaire inquires into specific activities such as the provision of community medical screening, immunization programs, informational programs and whether the hospital undertakes surveys to assess whether there are any unmet community needs.
- *Compensation Programs.* Part III of the Questionnaire focuses on employee compensation programs. Hospitals should make sure that they have policies that are designed to insure the reasonableness of the compensation and that executive compensation packages are documented.

Recent Congressional Inquiry

The IRS inquiries, coupled with the notoriety of the recent class action suits, have focused congressional interest on exempt hospital operations. On September 13, 2006, the Senate Finance Committee conducted hearings on the community benefit standards for tax-exempt hospitals. At the heart of the

inquiry is an effort to quantify the tax benefits that tax-exempt hospitals receive at the federal, state and local level in relation to the benefits they enjoy from their exempt status. As part of the inquiry, the Committee distributed a list of questions that were intended to identify the benefits these organizations provided to their communities. There was substantial interest in the hearings and it is likely that the hearings will result in a proposal calling for a common reporting system among all nonprofit hospitals for charity care and community benefit. Importantly, a ranking Committee official suggested that there was a need for uniform reporting in order to ascertain whether all nonprofit hospitals were providing similar benefits to their respective communities.[4] While it is still too early to know whether the hearing will result in legislation relating to the establishment of a community benefit standard for hospitals, it is likely to result in additional scrutiny upon the operations of these entities.

Next Steps for Exempt Hospitals

Clearly, public interest in the community benefits provided by exempt organizations will continue. For this reason, nonprofit hospitals should welcome the Questionnaire as an opportunity to fully communicate the extent and amount of services that they provide to their communities. In this regard, other hospitals should use the Questionnaire as the basis for internal discussions regarding their community benefit activities. Further, all hospitals should publicize their activities as part of a focused effort to educate the public on their good works. Comprehensive documentation will be critical for hospitals from this point forward. ■

1 For example, in Revenue Ruling 83-157, the IRS relaxed its position that every hospital have an emergency room, in favor of a more liberal position which did not require that a hospital have an emergency room in those communities were such services were readily available to the community from another facility.

2 General Counsel Memoranda are not binding precedent, but they are able to provide insight into IRS thinking on a particular topic.

3 However, in 2001, the IRS released Field Service Advice (a nonprecedential communication) which instructed agents to look critically at the amount of charity care the hospital actually provides.

4 The Committee questioned ten nonprofit hospitals and posted their responses at http://finance.senate.gov/sitepages/grassley.htm.

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Anti-Kickback

OIG okays PAP, financial aid, ambulance transport proposals

A pharmaceutical company's proposed patient assistance program (PAP), a proposal to provide financially needy beneficiaries with grants to defray the costs of Medicare premiums and cost-sharing obligations, and two proposals by municipalities to provide nonemergency interfacility medical transport services met the requirements necessary to be approved by the Office of Inspector General (OIG). OIG explained its position for each of these proposals in four advisory opinions issued from September 18 -26, 2006.

PAP for Medicare Part D enrollees. A pharmaceutical company's proposed patient assistance program (PAP) providing free outpatient drugs to financially needy Medicare Part D enrollees outside of the Part D benefit poses minimal risk of fraud and abuse under the Part D program, according to the OIG. The Special Advisory Bulletin for Medicare Part D Enrollees (see ¶760,011) noted that manufacturer PAPs that subsidize the cost-sharing amounts for the drugs payable by the Part D program present all of the usual risks of fraud and abuse associated with kickbacks.

The proposed PAP would provide enrollees with a monthly supply of drugs for a fixed fee of $25 per month for a given year to be dispensed through a mail order pharmacy created by the company. In addition, PAP enrollees would be required to certify that they would not submit a claim for reimbursement to a third party payer for any product provided under the PAP and will not claim out-of-pocket costs from a Part D plan. Because the PAP in question would be operated entirely outside the Part D benefit, the OIG would not initiate administrative proceedings to impose civil money penalties or exclude the manufacturer from federal health care programs.

Safeguards sufficient to mitigate the risk that the drugs would be used to bind Medicare beneficiaries to particular drugs payable by Part D and increase costs to the Part D program include the following: (1) notification to the enrollees' Part D plans that the drugs are being provided outside of the Part D benefit; and (2) eligibility for PAP assistance for Part D enrollees based solely on patients' financial needs and using a methodology that is entirely unrelated to the enrollee's choice of Part D plan. Therefore, the proposed arrangement would not constitute grounds for the imposition of sanctions.

OIG Advisory Opinion, No. 06-14, Sept. 26, 2006, Health Care Compliance Reporter, ¶500,148.

Grants to defray cost-sharing obligations. The OIG found that a proposed arrangement that would provide financially needy beneficiaries with grants to defray the costs of Medicare premiums and cost-sharing obligations would not violate Medicare or Medicaid

law. The law prohibits remuneration to a Medicare or Medicaid beneficiary that the benefactor knows, or should know, is likely to influence the beneficiary's selection of a particular provider, practitioner, or supplier of any item or service for which payment may be made, in whole or in part, by Medicare or Medicaid.

The arrangement would interpose an independent, *bona fide* charitable organization between donors and patients in a manner that effectively insulates beneficiary decision-making from information attributing the funding of their benefit to any donor. Thus, the OIG concluded that it appears unlikely that donor contributions would influence any Medicare beneficiary's selection of a particular provider, practitioner, supplier, or product, or the selection of any particular insurance plan. Similarly, there would appear to be a minimal risk that donor contributions would improperly influence referrals, the OIG said.

OIG Advisory Opinion, No. 06-13, Sept. 18, 2006, Health Care Compliance Reporter, ¶500,147.

Nonemergency interfacility medical transport service. In two similar advisory opinions, OIG said that although a municipality's proposed arrangement for nonemergency ambulance transport services could potentially generate prohibited remuneration under the anti-kickback statute, a number of factors in the arrangement mitigated the risk such that the OIG would not seek administrative sanctions. Under the proposed arrangement, commonly referred to as a "pay to play" arrangement, the city would adopt an ordinance making it the exclusive provider of nonemergency interfacility medical transport services. The city would then execute an exclusive contract with a provider through an open procurement process under which the provider would pay a flat yearly fee of $50,000 to the city.

While "pay to play" arrangements generally run afoul of the anti-kickback statute, because the city's proposed arrangement would procure a provider through a competitive process, competition would not be adversely affected, and the city would be accountable to the public through the political process for the quality of the services rendered, the OIG said. In addition, the remuneration would be in the form of a yearly flat fee regardless of the value or volume of referrals between the parties. The city also certified that the $50,000 fee will only partially offset the costs of operation, so the concern that the provider would be overpaying the source of referrals is lessened. Finally, the risk of patient steering under this arrangement is low and the annual fee inures to the public, and not private benefit, through improved services, OIG concluded.

OIG Advisory Opinion, No.06–11, No.06-12, Sept. 25, 2006, Health Care Compliance Reporter, ¶500,145, ¶500,146.

Fraud & Abuse

Tenet CIA includes board of director review

Following allegations of upcoding, improper outlier payments, kickbacks to physicians, and other fraudulent activities, Tenet Healthcare Corporation (Tenet) agreed to pay $900 million to resolve its liability to the government. According to a statement by the Office of Inspector General (OIG), the corresponding five-year corporate integrity agreement (CIA) contains "comprehensive and unprecedented provisions designed to prevent future harm to the programs."

The specific charges alleged that Tenet submitted claims for payment to Medicare using diagnosis related group codes that Tenet could not support or were improperly assigned to patient records to increase reimbursement. In addition, Tenet allegedly inflated its charges in excess of any increase in the costs associated with patient care, which resulted in improper outlier payments.

Terms of the CIA. Under the CIA, Tenet is required to implement a comprehensive compliance program that includes corporate, regional, and hospital compliance officers; compliance policies and training; an employee hotline and reporting mechanism, and mandatory reporting and repayment of overpayments. In addition, the CIA requires that an independent review organization review all diagnosis related group claims, outlier payments, physician relationships, and clinical quality management.

The CIA also includes provisions requiring Tenet's board of directors to undertake a review of the effectiveness of Tenet's compliance program and adopt resolutions with respect to this review.

Divestiture of Alvarado. According to the OIG, Tenet is bound to comply with a divestiture agreement entered into on May 17, 2006, following unrelated allegation of kickbacks to physicians. Under the terms of that agreement, Tenet must divest Alvarado Hospital Medical Center to an unrelated third party to avoid exclusion of Alvarado. The OIG continues to monitor Tenet's compliance with that agreement. ■

OIG Press Release, Sept. 28, 2006, Health Care Compliance Reporter, ¶420,347.

In the News

CMS seeks to award MAC contracts

By July 2007, CMS expects to have awarded three new Medicare administrative contractor (MAC) contracts as part of Medicare contracting reform established under §911 the Medicare Modernization Act of 2003 (PubLNo 108-173). CMS released a Request for Proposal (RFP) for three of 15 separate contracts for the MACs and plans to issue a separate RFP for four other MAC jurisdictions in December 2006, and additional RFPs in 2007 for the remainder of the 15 MAC jurisdictions. Together the three MACs will be responsible for 23 percent of the total Medicare fee-for-service workload, comprised of claims from the following jurisdictions: Jurisdiction 4 – Colorado, New Mexico, Oklahoma, and Texas; Jurisdiction 5 – Iowa, Kansas, Missouri and Nebraska; Jurisdiction 12 – Delaware, the District of Columbia, Maryland, New Jersey and Pennsylvania. Fact sheets for Jurisdictions 4, 5, and 12 along with additional information on Medicare contracting reform can be found at http://www.cms.hhs.gov/MedicareContractingReform/.

CMS News Release, Sept. 29, 2006.

Nearly all hospitals report quality information

Ninety-nine percent of the nation's 3,490 acute care hospitals eligible to receive a 2 percent annual payment update from Medicare reported data on the quality of care they deliver, providing transparency in information for consumers on quality performance measures linked to payments hospitals receive for treating Medicare beneficiaries, CMS has announced. Only 171 eligible hospitals failed to meet the fiscal year (FY) 2007 reporting requirements (143 failed the submission requirements and 28 chose not to participate). Hospitals that did not meet the quality data requirements for FY 2007 may exercise their right to appeal and submit a letter to CMS outlining its reasons for requesting reconsideration by no later than November 1, 2006. Although reporting is voluntary, those hospitals that do not report will get a 2 percent reduction in their annual Medicare fee schedule update, a much greater impact than last year's 0.4 percentage point reduction. For 2007, an additional 11 measures were added to the 10-measure starter set. For more information on Hospital Quality Data for Annual Payment Update, visit http://www.cms.hhs.gov/HospitalQualityInits/.

CMS News Release, Sept. 29, 2006.

Stanford bans drug company gifts

Stanford University Medical Center has joined a growing number of academic medical centers, including Yale Medical Group and the University of Pennsylvania, who have adopted a policy aimed at limiting the potential influence of pharmaceutical and other biomedical companies in its day-to-day clinical and educational activities. The new policy, which took effect on October 1, 2006, prohibits physicians from accepting industry gifts of any size, including drug samples, anywhere on the medical center campus or at off-site clinical facilities where they may practice. It also bans pharmaceutical, bio-device and related industry representatives from patient care areas and medical school facilities except for in-service training on devices and equipment and by appointment only, as well as allowing industry support of educational activities only under well-regulated conditions.

Stanford University Medical Center Press Release, Sept. 12, 2006.