CCH Health Care Compliance LETTER

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Continual assessment is key to compliance program effectiveness

by Geri Szuberla, J.D., Contributing Editor

As an organization grows and changes, having a continual assessment process for the organization's health care compliance program will ensure that the program remains effective, according to Lisa Eggleston, a CMS health insurance specialist who participated in an audioconference presented by the Health Care Compliance Association on November 29, 2007. Along with F. Lisa Murtha, Managing Director of Huron Consulting Group, Eggleston discussed the results of CMS' Compliance Effectiveness Study that began in late 2004.

The study was focused on a small sample of health care providers and included site visits, interviews with staff, and survey questionnaires to assess health care compliance programs. Eggleston pointed out that an effective compliance program leads to efficient billing and payment of claims. It is less expensive to have a claim paid correctly when first submitted than to go through the appeal process, she said. Participants in the CMS study found that billing outcomes improved after they looked at their claims processing data.

Setting the tone. Murtha addressed the question of how to make sure a compliance program is working effectively. The tone must be set at the top of the organization, which is why it is important for a compliance officer to be a part of top management, she said. The compliance officer or consultant should walk the halls of the organization, asking individuals about their personal experience with and confidence in the program. A true measure of success, she emphasized, is when compliance is part of what everyone does. Continuing education of all staff and open lines of communication will increase the effectiveness of reporting mechanisms, Murtha stressed.

At least one staff member's job description should include researching compliance rules on a weekly basis, Murtha added, and the effectiveness of staff compliance training should be assessed on a regular basis by testing or whatever means is best for the organization. Murtha also recommended that organizations document all compliance activities, so that the cost of the program is justified for the organization.

Best practices. There are not a lot of published best practices, Murtha noted, so the best way to find them is through networking with other compliance professionals and by attending conferences. Murtha urged organizations to look for opportunities for improvement in the level of understanding for all organization staff, such as providing information on the consequences of noncompliance. As a starting point, she noted that HHS defines "effective" as a program that prevents

Wolters Kluwer Law & Business

Trends (cont.)

improper payments. Beyond that basic guideline, an effective compliance program builds within an organization the structure and culture of best business practices, thus facilitating the delivery of superior patient care, Murtha added.

The "true value" of an effective compliance program does not derive solely from program implementation and the program's ability to protect itself from those risks identified by the organization, according to Murtha; instead, "true value" is derived from the organization's implementation of best practices, which contribute to improved organizational performance and patient care. ■

CCH Chicago Bureau, Nov. 29, 2007.

Fraud & Abuse

Subcommittee seeks system to levy Medicaid funds

by Hilary Goehausen, Contributing Editor

Medicaid payments disbursed to providers who are delinquent in their federal tax obligations do not qualify as "federal payments" that can be levied-on through the government's Federal Payment Levy Program (FPLP), said Internal Revenue Service (IRS) Acting Commissioner Linda Stiff during a November 14, 2007, hearing before the Senate Permanent Subcommittee on Investigations. The hearing was the "fifth in a series before the subcommittee on federal contractors who are paid with taxpayer dollars but fail to pay their taxes," subcommittee chairman Sen. Carl Levin (D-Mich.) explained in a statement during the hearing.

A Government Accountability Office (GAO) report, entitled "Medicaid: Thousands of Medicaid Providers Abuse the Federal Tax System," was released in conjunction with the subcommittee's hearing. The GAO report found that more than 30,000 Medicaid providers, which is approximately five percent of those receiving payment in fiscal year (FY) 2006, had accumulated more than $1 billion in unpaid federal taxes as of September 30, 2006.

Tax levy law. The focus of the subcommittee hearing was to determine whether federal tax levy law should be amended to permit the government to attach a portion of Medicaid payments being made to providers who are delinquent in paying their federal taxes. Levin said these tax delinquents include nursing homes, doctors, and other medical providers who are paid through Medicaid but have failed to meet their federal tax obligations. According to the GAO report, if the IRS had a successful system in place to levy a portion of the Medicaid payments, the federal government may have been able to collect between $70 and $160 million during FY 2006.

Both Stiff and CMS Director Dennis G. Smith explained to members of the subcommittee that, while payments to Medicare providers are federal payments for purposes of the FPLP that can be brought under the continuous levy program, Medicaid payments are not considered "federal payments" and, therefore, are not eligible for the FPLP.

State responsibility. The FPLP cannot succeed as a mechanism through which to tackle the problem, Stiff and Smith explained, because the Medicaid program is structured and run by the states. Unlike Medicare, in the Medicaid program the federal government sends funding to states, which administer the program and make payments to providers. Because the state Medicaid agencies have operational discretion as well as responsibility for nonpayments, they are the recipients of the funds, which prevents the payments from constituting "federal payments" under Internal Revenue Code §6331.

Recommendations. Witnesses from the various agencies included Stiff, Smith, Gregory Kutz, Managing Director of GAO Forensic Audits and Special Investigations, and Kenneth Papaj, Commissioner of the Financial Management Service (FMS) of the Treasury Department. Sen. Levin requested that the IRS, GAO, CMS and the FMS provide the subcommittee with recommendations on how to design a system to levy Medicaid payments and increase federal tax levy payments within 30 days.

Levin also inquired as to whether a national registry of delinquent Medicaid providers could be created. Stiff, Smith and Papaj responded that such a registry would raise taxpayer privacy questions and would be extremely difficult. ■

CCH Washington Bureau, Nov. 14, 2007.

CCH Health Care Compliance Letter

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Form 990 redesign raises concerns for nonprofit groups

by Torie Cole, Contributing Editor

The recently proposed Form 990 distorts public understanding and hurts organizations the public wishes to help and support, according to nonprofit industry representatives. During a November 15, 2007, telephone conference, Clara Miller, President and Chief Executive Officer (CEO) of the Nonprofit Finance Fund, and Robert Ottenhoff, President and CEO of Guidestar, discussed their recommendations for amending Form 990, and emphasized the need to design a form that presents a clearer picture of nonprofit organizations for the nonprofit donor community. In June, the Internal Revenue Service (IRS) released a revised Form 990 for a public comment period that closed on September 14, 2007.

Theresa Pattara, IRS project manager for the Form 990 revision project, told practitioners at a Washington, D.C. Tax Bar meeting in October that the IRS had received 3,000 pages of comments on the proposed revision of Form 990. Pattara said that the IRS is retaining many aspects of its proposal but also is making changes in response to comments. Now that the official period for submitting comments has closed, she added that the IRS Exempt Organizations division is attempting to make quick decisions about the form.

Criticisms of the revised form Miller took issue with what she perceived as an arbitrary focus in the proposed form on reporting program expenses, salaries, break-even results or deficits, and minimizing financial reserves. According to Miller, emphasizing these measurements implies to a potential donor that the entity's management has failed or succeeded in meeting a certain standard of performance; even though no such standard based on this data exists.

"The bottom line is that most of what people think they know today about how to evaluate nonprofit efficiency and finances is wrong and much of this stems from the way data is reported on the IRS Form 990," Miller stated. According to Miller, this misperception "creates an environment where nonprofits are penalized when they do what any effective, well-run enterprise should do: build for the future, invest in up-to-date systems, train and promote the best people, and hedge against risk." She added that "partly because of these rules, many nonprofits are hamstrung when they do such important work as protecting our health, our children, and shielding vulnerable people from harm. This doesn't serve the public good."

Given the impact Form 990 has on donors' decisions to give funds to any particular organization, Ottenhoff called for a "less is more" approach to make the form a more focused and simpler document. Although the proposed Form 990 has as its main goal the reporting of information to the IRS for tax purposes, Ottenhoff advocated for a version in which "information... collected is actually information that will inform a decision maker and help [him or her] make better and more accurate decisions or conclusions about an organization."

Seeking transparency. Both Miller and Ottenhoff stated that the Form 990 currently only offers partial transparency as to the true situation of many nonprofits. Ottenhoff emphasized that his company, as well as the industry in general, is dedicated to providing more transparency in the charitable giving area. Since 1999, Ottenhoff's company has posted Forms 990 for its charities on its webpage. Ottenhoff reported that "in the beginning, we got a lot of push back from nonprofit organizations ... and now ... we hear just the opposite.... What I think that represents is a profound change and a commitment to transparency and accountability that maybe wasn't there 10 years ago."

Miller also emphasized that her organization is requesting a Form 990 that represents "true information." She concluded that, if the form is truthful to donors, it ultimately will make charities more effective in improving the community at large. ■

CCH Washington Bureau, Nov. 15, 2007.

New safe harbor protects certain financial arrangements involving federally qualified health centers

by Michael A. Dowell, Esq., Contributing Editor

On October 4, 2007, the HHS Office of Inspector General (OIG) published a final rule[1] establishing a new anti-kickback safe harbor for certain financial arrangements involving federally qualified health centers (FQHCs). This article summarizes the new safe harbor provisions and provides insight into their origin.

The safe harbor protection under the anti-kickback statute for certain financial arrangements involving FQHCs addresses donations, loans, and the furnishing of items, goods, and services to certain federally-funded health centers, including FQHCs and Indian health centers ("health centers"). The safe harbor protects arrangements in which entities and individuals (namely hospitals, specialty physicians, and other health care providers and suppliers) ("donors"), furnish these sorts of loans, services, and other items to health centers, if the arrangements meet certain safe harbor criteria.

The intent behind the new safe harbor criteria originates from OIG Advisory Opinion 01-09,[2] issued on July 19, 2001. In that opinion, the OIG approved an arrangement between a health center and a local community-based hospital under which the health center assumed financial and operational responsibility for certain services provided at an outpatient clinic previously operated (at a substantial loss) by the hospital, to avoid either closing the clinic or significantly curtailing the services provided. To do so, however, the health center required a grant from the hospital to defray a portion of the costs of providing otherwise uncompensated health care services to patients served at the clinic (including an expected increase in uninsured patients).

In approving the arrangement, the OIG recognized that charitable donations are essential in "sustaining and strengthening the health care safety net for the insured and uninsured." Further, the OIG determined that the arrangement would not result in a high risk of abuse of federal health care programs, based on the following factors:

- The proposed grant furthered the shared charitable missions of the parties by ensuring the continuity of care for current clinic patients and the availability of services for all underserved residents of the community.
- Because the costs covered by the proposed grant otherwise would be covered by other health center funds, including §330[3] dollars, the proposed grant "indirectly relieves the burden on the Federal treasury."
- The grant agreement did not contain any restrictions or limitations (other than to expend the funds to pay for the costs of uncompensated care); the amount of the grant was fixed and would not vary based on the volume or value of referrals or other business generated between the parties; at the end of the grant year, the parties would perform a reconciliation between the amount of funds awarded and the costs of uncompensated care, and any funds in excess of costs would be returned to the hospital; and the funds themselves did not include any discount, rebate or reduction in charge.
- Because the hospital agreed to accept all referrals of health center patients regardless of the patients' ability to pay, additional uninsured referrals would offset any potential benefit obtained by the hospital due to the parties' business relationship.
- The arrangement contained other safeguards and low risk factors, and the ancillary agreements necessary to implement the arrangement (*i.e.*, leases for space, equipment, and personnel) complied with applicable safe harbors.

A notable difference between the 2001 OIG Advisory Opinion and the new safe harbor is that the safe harbor imposes certain administrative tasks on the health center, which are discussed in more detail below.

Health centers and their donors may want to evaluate their current arrangements in light of the OIG's newly published criteria to determine whether current or future arrangements satisfy the requirements or if changes in their practices will be necessary. For example, health centers should consider developing the infrastructure outlined in the safe harbor criteria to assess and accept discounted and free goods and services from donors.

Background—the anti-kickback statute. The anti-kickback statute makes it a felony to knowingly and willfully offer, solicit, pay, or receive anything of value, directly or indirectly, in exchange for or to induce referrals of items or services reimbursable by Medicare or Medicaid.[4] The OIG may impose civil money penalties or exclude an individual or entity from participation in any federal or state health care program for violating the anti-kickback statute. An arrangement will not be subject to such sanctions, however, if the

arrangement meets the criteria of a safe harbor. Importantly, the failure to qualify for a safe harbor does not mean that an arrangement is illegal. Instead, arrangements that do not meet the safe harbor criteria should be reviewed on a case by-case basis to ensure that they do not involve unlawful payments for referrals of Medicare or other federally-funded program patients.

Background—FQHCs. An FQHC is a type of provider defined by the Medicare and Medicaid statutes. Health centers include all organizations receiving grants under §330 of the Public Health Service Act, certain tribal organizations, and FQHC look-alikes.[5] Section 330 grant recipients, which are nonprofit tax-exempt entities, play a vital role in the health care safety net, providing cost effective care for communities with limited access to health care resources. Health centers must serve a population that is medically underserved, or a special medically underserved population comprised of migratory and seasonal agriculture workers, the homeless, and residents of public housing. Health centers must be community based, and a majority of a health center's board must be users of the health center and, as a group, must represent the individuals being served by the health center. Health centers receiving §330 grant funding must provide, either directly or through contracts or other arrangements, a broad range of required primary health care services. Section 330 grant funds are intended to defray the costs of serving uninsured patients. Grant recipients are required to seek reimbursement from those patients who are able to pay all or a portion of the charges for their care (applying a sliding fee schedule adjusted on the basis of the patients' ability to pay) or obtain payment from Medicare or Medicaid.

"Health centers and their donors may want to evaluate their current arrangements in light of the OIG's newly published criteria to determine whether current or future arrangements satisfy the requirements or if changes in their practices will be necessary."

The new safe harbor. The safe harbor is intended to protect the transfer of goods, items, services, donations, and loans to a health center if those items contribute to the availability and quality of "safety net" health care services to medically underserved populations; and to prevent parties from entering into agreements in exchange for referrals of patients to a donor. The safe harbor requires that the following criteria be met when a donor furnishes any of these items of value to a qualifying health center at other than fair market value:

- Under an arrangement with a donor, the goods, services, or other items furnished to a health center or supported by a loan or donation must be medical or clinical in nature or relate directly to patient services (*e.g.*, billing services, administrative support, technology support, enabling services, such as transportation, and translation services) provided by the health center as part of the scope of the health center's §330 grant.
- The health center must reasonably expect the arrangement to contribute to its ability to maintain or increase the availability of, or enhance the quality of, services provided to a medically underserved population. Health centers must document the basis for their determination that the arrangement will yield such a benefit prior to entering into the arrangement and must periodically (no less than annually) evaluate agreements to ensure ongoing compliance with the benefit standards. Arrangements may not be renewed or renegotiated unless the health center expects the arrangement to comply with the benefit standards in the next agreement term.
- Health centers must not be required to refer patients to a particular provider or supplier under the arrangement or prohibit the health center from referring patients to any individual or entity.
- Individuals or entities that offer to furnish goods, items, or services for health center patients must furnish those goods, items, or services to all health center patients who clinically qualify for them, regardless of payor status or ability to pay. The individual or entity may impose reasonable limits on the aggregate volume or value of the goods, items, or services furnished under the arrangement with the health center, provided that such limits do not take into account a patient's payor status or ability to pay.
- Health centers are required to provide effective notification to patients of their freedom to choose any willing provider or supplier and to disclose to patients, upon request, the existence and nature of the arrangement with the donor.
- Finally, certain standard safe harbor criteria must be met. The arrangement must be pursuant to a contract, lease, grant, loan, or other arrangement that is set out in writing, signed by all the parties, and covers all the items to be provided to a health center by the individual or entity. The written agreement must specify the amount (meaning a fixed sum, percentage, or other fixed methodology) of the items to be provided to a health center. The amount may not vary based on the volume or value of Medicare or Medicaid program business generated between a health center and a donor.

Conclusion. The new rule issued by the OIG will make a dramatic difference in the care and services that FQHCs can provide to patients. Health centers are now free to develop unique partnerships, affiliations, and joint ventures with other providers and entities to design the best care tailored to meet the health care needs of their communities without extra costs to taxpayers.

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1 *Final rule*, 72 FR 56632, Oct. 4, 2007.

2 *OIG Advisory Opinion*, No. 01-09, July 19, 2001.

3 Section 330 of the Public Health Service Act (41 U.S.C. §254b) is the authorizing legislation of the health center program.

4 42 U.S.C. §1320a-7b.

5 FQHC look-alikes are health centers that meet all of the eligibility requirements of an organization that receives a §330 grant, but do not receive grant funding.

EMTALA

EMTALA settlements decline after 2006 spike

by Laura J. Merisalo, Contributing Editor

In its semiannual report to Congress in June, the HHS Office of Inspector General (OIG) revealed a sharp drop in the number of settlements related to the Emergency Medical Treatment and Active Labor Act (EMTALA), and in the related civil monetary penalties (CMPs) collected.

In the first six months of federal fiscal year (FY) 2007, the OIG reported collecting $80,000 in total CMPs from three hospitals under EMTALA settlements—one-fifth of the amount collected during the same six-month period in FY 2006, when the OIG collected $345,000 from 12 hospitals and one physician. In the first six months of FY 2005, CMPs collected as part of EMTALA settlements totaled $242,000. The OIG reported a total of $455,000 in CMPs collected from 18 hospitals pursuant to EMTALA settlements for all of FY 2005. In FY 2006, 19 hospitals paid $680,000 in EMTALA settlements. With collections at a low of $80,000 in the first half of FY 2007, it appears that settlements based on alleged EMTALA violations will be curbed significantly in this fiscal year.

Background. Enacted nearly two decades ago, EMTALA (sometimes referred to as the patient "anti-dumping" law) is designed to ensure that patients who present to an emergency department (ED) receive appropriate medical care regardless of their ability to pay. This law is of significant concern to patient access professionals, as it has served to complicate the ED registration process considerably. Although EMTALA is touted as a security blanket to ensure that patients who believe they need emergency care receive a medical screening exam and treatment, as needed, the OIG each year includes EMTALA reviews within its annual work plan to ensure compliance so that it remains so.

OIG scrutiny. In recent years, the OIG has reported more than a dozen settlements stemming from alleged EMTALA violations, the majority of which are linked to actions of clinical staff members. There are, however, instances in which the actions of front-end ED employees can result in allegations of EMTALA violations. For hospitals, the results of failing to comply with EMTALA requirements can be costly. For patients, the results can range from inconvenient to tragic, as revealed in the following instances of recent EMTALA settlements that involve front-end staff members. (*See* http://oig.hhs.gov/fraud/enforcement/administrative/cmp/cmpitemspd.html#5).

- In May 2006, a Chicago hospital agreed to pay $35,000 to resolve allegations that it failed to accept the transfer of a patient who presented to another ED complaining of flank pain. The hospital had specialized capabilities not available at the transferring hospital, but allegedly refused to accept the transfer after learning the patient did not have insurance. The facility later agreed to accept the transfer, but only if the patient provided proof of funds in a bank account. The patient was transferred to another hospital, where he died.
- In February 2006, an Indiana hospital paid $10,000 to settle allegations that it failed to provide a medical screening exam to a two-year-old boy who presented in the ED with his grandmother after squirting bug spray in his eyes. Upon learning the boy was covered under Medicaid, a registration employee allegedly informed the child's grandmother that she would have to take the boy to a different facility.
- In March 2005, a Puerto Rico hospital agreed to a $10,000 settlement to resolve allegations that it failed to provide a medical screening examination to a three-year-old boy based on his family's inability to pay. According to the OIG allegations, the boy did not have health insurance and the admissions department requested that his mother pay a private-pay deposit of $2,150. The boy did not receive a medical screening examination. The mother took her son to another hospital where he was hospitalized for four days and treated for right bronchopneumonia and maxillary sinusitis.
- In March 2005, an Illinois hospital paid $15,000 to settle allegations that its staff discharged a patient based on her lack of insurance without providing an appropriate medical screening. The hospital staff allegedly asked the patient whether she had insurance, and she responded that she did not. Without providing any further medical screening, the hospital allegedly discharged the patient a few minutes later.

Based on the FY 2007 information to date, none of the EMTALA settlements involved violations by front-end personnel. Still, EMTALA violations are a serious issue, and ED registration employees need to understand the requirements under EMTALA to ensure compliance as OIG scrutiny continues.

The implications of failing to comply with EMTALA are serious. In addition to fines per occurrence, Medicare providers may risk being expelled from the federal health care program if found in violation of the patient anti-dumping law. Fines may range from up to $25,000 against small hospitals (those with fewer than 100 beds) and up to $50,000 against hospitals with 100 beds or more for each instance in which the hospital negligently violated EMTALA.

Best practices. Although most ED providers avoid potential EMTALA violations due to the actions of patient access employees by simply avoiding any detailed data gathering at registration, the federal law does not prohibit reasonable "registration processes, which typically include the collection of demographic information, whom to contact in an emergency, and other relevant information," according to an OIG guidance published in the *Federal Register*. (*See* 64 FR 61353, Nov. 19, 1999). Rather, EMTALA mandates that gathering registration data related to insurance coverage and patient issues cannot delay or take priority over providing ED patients with a medical screening examination and, as needed, stabilizing treatment.

The OIG guidance clarifies, however, that EMTALA does not bar registration employees from gathering data from ED patients. In its guidance, the OIG notes that interpretive EMTALA guidelines indicate that a hospital "may continue to follow reasonable registration processes for individuals presenting with an emergency medical condition," and that reasonable processes "may include asking whether an individual is insured and, if so, what that insurance is, as long as this inquiry does not delay [medical] screening or treatment."

Specifically, the OIG provides the following guidance for hospitals to develop practices within the ED that are in compliance with the patient anti-dumping statute:

- Do not seek prior authorization from health plans, as required by health plans to secure future reimbursement, before initiating the medical screening examination or stabilizing medical services. The OIG notes in its guidance, however, that a hospital "may seek authorization for payment for all services after providing a medical screening examination and once necessary stabilization treatment is underway."
- Do not delay the medical screening exam or stabilizing treatment to prepare financial responsibility forms, including an advance beneficiary notice (ABN) that requires a Medicare beneficiary signature. Similar to managed care plan preauthorization requirements, the Medicare program requires that patient access employees secure an ABN prior to service if reimbursement for those services is likely to be denied by Medicare to allow providers to bill patients for services provided. Emergency care, however, is the exception. In its guidance, the OIG clarifies that Medicare managed care plans "may not require prior authorization for emergency services." Further, the OIG notes these health plans must pay for emergency services that are pursued by patients based on the prudent layperson standard, which means that the need for emergency care is determined based on a reasonable patient's perspective at the time symptoms present.
- Train front-end ED staff members on the hospital's EMTALA obligations, including how to respond to patient inquiries about their financial liability for emergency services prior to those services being provided. The OIG underscores that staff members responding to such inquiries "should clearly inform the patient that, notwithstanding the patient's ability to pay, the hospital stands ready and willing to provide a medical screening examination and stabilizing treatment, if necessary." The OIG indicates that additional best practice when patients do inquire about their financial obligations for emergency care is to encourage patients to defer financial discussions until after the medical screening exam has been performed.
- Document, to the greatest extent possible, patients who voluntarily choose to leave the ED without receiving a medical screening examination. In situations when patients inform staff of their plans to leave prior to receiving an exam or treatment, ED staff members should (1) offer the medical screening exam and treatment; (2) inform patients of the benefits of a medical exam and treatment, as well as the risks of leaving prior to receiving such an exam and treatment; and (3) take steps to secure written informed consent of patients who refuse the medical screening exam and treatment. In instances when patients leave the ED without notifying staff, the hospital should document when it was discovered that the patient left, and all notes related to the patient presentation to the ED should be retained. The OIG underscores that even when patients voluntarily leave the ED, "the burden rests with the hospital to show that it has taken appropriate steps to discourage an individual from leaving the hospital without evaluation."

In summary. Although allegations of EMTALA violations have been on the decline in FY 2007, it remains imperative that patient access professionals continue to receive training and education on the facility's EMTALA obligations to ensure ongoing compliance. At the same time, patient access leaders should take steps to ensure that so-called reasonable registration processes occur within the ED, to best serve the organization and its patients. The enactment of EMTALA continues to infringe on the comfort level of patient access professionals to gather registration data in the ED. A solid understanding of this federal law, however, can set the stage for effective ED registration, within the confines of EMTALA regulations. ■

Healthcare Registration, Vol. 16, No. 11, Aug. 2007.

Quality of Care

Health IT measures included in 2008 PQRI

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

CMS has outlined new quality measures for inclusion in the 2008 Physician Quality Reporting Initiative (PQRI), including structural measures that focus on whether physicians and health care professionals use electronic health records and e-prescribing technology. The 2008 PQRI measures were released in the Medicare Physician Fee Schedule *Final rule*, which was published in the *Federal Register* on November 27, 2007.

CMS implemented the PQRI in 2007, pursuant to the Tax Relief and Health Care Act of 2006 (PubLNo 109-432). The PQRI is a voluntary reporting program whereby physicians and other eligible health care professionals who report specific measures on quality of care furnished to Medicare beneficiaries may earn incentives up to 1.5 percent of their total allowed charges, subject to a cap.

The 2008 quality measures were derived from the following sources: (1) measures selected from the 2007 PQRI quality measures; (2) measures under development by the American Medical Association Physicians Consortium for Performance Improvement; (3) nonphysician and structural measures currently under development by the Pennsylvania Medicare Quality Improvement Organization; (4) AQA Alliance starter set measures; (5) measures endorsed by the National Quality Forum; and (6) measures currently under development by the American Podiatric Medical Association.

In 2008, physicians and nonphysician health care professionals not meeting PQRI measures will be allowed to participate in the initiative by reporting on their use of health information technology. According to CMS, "These structural measures ... emphasize the importance of [electronic health record and e-prescribing] technology for delivery of high-quality health care services."

The Physician Assistance and Quality Initiative Fund will provide $1.35 billion for physician payment and quality improvement initiatives for services provided in 2008. ■

Final rule 72 FR 66221, Nov. 27, 2007; CMS Press Release, Nov. 1, 2007.

In the News

Infection control standards for hospitals updated

The hospital interpretive guidelines regarding infection control have been revised. Due to changing infectious disease threats, as well as new mechanisms to confront these threats, the guidelines have been updated to reflect current conditions within hospitals as well as contemporary infection control standards of practice. The revised guidelines discuss: (1) applicable requirements for the infection control condition of participation and related standards; (2) survey procedures to be used to determine compliance; and (3) practices that hospitals are encouraged to adopt. The revised guidelines are effective immediately. ■

CMS Letter to State Survey Agencies, No. 08-04, Nov. 21, 2007, Health Care Compliance Reporter ¶350,065.

Stark Phase III provisions delayed

Application of the "stand in the shoes" provisions of the Stark II Phase III final rule (72 FR 51012, Sept. 5, 2007) to certain compensation arrangements has been delayed until December 4, 2008. The delay is only applicable to compensation arrangements between the following physician organizations and entities: (1) with respect to an academic medical center (AMC), as described in 42 C.F.R. § 411.355(e)(2), compensation arrangements between a faculty practice plan and another component of the same AMC; and (2) with respect to an integrated tax-exempt health care system, compensation arrangements between an affiliated designated health service entity and an affiliated physician practice in the same integrated tax-exempt health care system. The delay is a response to comments on the application of the "stand in the shoes" provisions in the AMC setting or similar settings where "support payments" or other similar monetary transfers are common. The delay of the provisions will give CMS time to evaluate the impact of the "stand in the shoes" provisions on remunerative relationships within AMCs and nonprofit integrated health care systems that, prior to Phase III, did not trigger application of the physician self-referral laws. ■

Final rule, 72 FR 64161, Nov. 15, 2007, Health Care Compliance Reporter ¶700,054.

Therapy provider settles FCA allegations

Physiotherapy Associates, Inc., a Memphis, Tennessee based outpatient therapy provider and its former parent company, the Michigan based Stryker Corporation, have agreed to pay the United States $16.6 million to settle allegations that they submitted false claims to Medicare and other federally funded health care programs in violation of the federal False Claims Act (FCA). The complaint alleged that Physiotherapy: (1) submitted claims for services to Medicare, state Medicaid programs, and the Department of Defense's TRICARE program that were falsely billed as one-on-one services; and (2) improperly retained excess or duplicate payments it received from federal health care programs. The complaints were initially filed by two former employees of Physiotherapy, under the FCA's whistleblower provisions. The whitsleblower provisions allow private parties to bring actions on behalf of the United States and receive a portion of the settlement or judgment if the government intervenes in the case. The whistleblowers in this case each will receive approximately $3 million as part of the settlement with the government. ■

DOJ Press Release, Nov. 14, 2007.