G-2 Compliance Report

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For Hospitals, Laboratories and Physician Practices

Congress Gives Brief Reprieve on Medicare Pay Cut

Christmas came early this year for pathologists and other physicians as Congress, shortly before adjourning for the year, agreed to a reprieve on planned Medicare pay cuts. The bad news is that the reprieve is only for six months.

The legislation (S. 2499) provides physicians a six-month Medicare payment increase and extends funding for the State Children's Health Insurance Program (SCHIP) until March 2009. The Senate passed the bill December 18, and the House approved it a day later.

S. 2499 also extends for six months the provision that allows independent clinical laboratories to continue to bill Medicare directly for the technical component of certain pathology services provided to hospitals. The so-called "grandfather" protection was slated to end Dec. 31, 2007. The protection applies to hospital-lab arrangements in effect as of July 22, 1999. The Centers for Medicare and Medicaid Services (CMS) has tried repeatedly to end the protection, but Congress has intervened several times to stay the agency's hand. Lab groups support making the protection permanent.

The $6 billion bill includes extensions of Medicare policy and cuts spending for Medicare managed care plans, *Continued on p. 2*

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CMS Ends Incentives for Pod Labs

Effective January 1, the Centers for Medicare & Medicaid Services (CMS) will limit the ability of physicians to mark up diagnostic tests performed by outside suppliers.

The new provision will make it significantly more difficult for physicians to purchase diagnostic tests, such as pathology and imaging services, from outside suppliers and then mark up those services when billing Medicare.

CMS was motivated by concerns that these arrangements led to increased use of diagnostic services as physicians attempted to profit from the markup on these services. By eliminating the possibility of a markup, CMS clearly expects to eliminate that incentive.

The anti-markup provision is contained in the Medicare physician fee schedule (PFS) final rule, which was released November 1 and published in the *Federal Register* on November 27. For an in-depth discussion of the effect of the anti-markup provision, see *Perspectives* on page 4.

Reprieve, *from page 1*

but only by $1.5 billion. A presidential veto is considered unlikely.

The bill is the culmination of several months' work by the Senate Finance Committee, but the final legislation does not come close to mirroring the initial wishes of many members of the committee or that of the House, which passed sweeping Medicare legislation (H.R. 3162) in August as part of a bill reauthorizing SCHIP for five years.

Alan Mertz, president of the American Clinical Laboratory Association, tells *GCR* that while ACLA is pleased that Congress intervened to stay the cuts, the association had hoped for a longer reprieve.

"While we're disappointed that the payment and grandfather provisions weren't extended for a full year, the silver lining is that it gives us another chance to stop the competitive bidding demonstration before it goes into effect," he says, adding that there is widespread support in Congress for a repeal of the demo.

Pay Cut Canceled

The bill would provide doctors a 0.5% payment increase through June 30, 2008, canceling a 10.1% cut scheduled to take effect Jan. 1, 2008. Congress will have to address the issue again in mid-2008 to avoid yet another payment cut for doctors from taking effect July 1, 2008.

The measure contains numerous provisions extending current Medicare payment policy, including an extension of reasonable cost payments for certain clinical diagnostic laboratory tests in rural areas through June 30, 2008. It also includes a permanent freeze at 60% of the compliance threshold for inpatient rehabilitation facilities, regulatory relief for long-term care hospitals, and extension of the qualified individual, or QI program.

S. 2499 also includes a provision that authorizes reimbursement for certain diabetes laboratory tests that are approved for home use at the same rate as other glycated hemoglobin tests, beginning April 1, 2008.

The package also would impose a six-month delay on the implementation of proposed Medicaid regulations from the Centers for Medicare & Medicaid Services related to school-based services and rehabilitation services.

Medicare managed care plans likely were the biggest winners in the package, not for what it contains, but for what it does not. The Finance Committee at one juncture was contemplating cutting managed care payments by as much as $20 billion over five years, and the House in its bill included more than $50 billion in reductions to plans.

As late as December 17, the Finance Committee still was considering cutting indirect medical education program payments to health plans, but the provision was dropped, and in the end, Congress will take only $1.5 billion from the managed care stabilization fund to help fund the package.

Offsets in Bill

Other offsets in the bill include a freeze in the payment update for long-term care hospitals for the last quarter of 2008 and a freeze in Medicare payment to inpatient rehabilitation facility payments from April 1, 2008, through fiscal 2009. Several other providers, such as home health agencies, skilled nursing facilities, and home oxygen suppliers, also avoided having their Medicare reimbursement reduced.

Congressional observers believe lawmakers will try again in June 2008 to cut managed care to fund another doctor payment fix. Although with President Bush in the White House and Democrats still lacking votes to override vetoes, managed care funding probably will be spared from cuts through next year.

Although physicians will get a tempo-

rary reprieve from the pay cuts, many industry groups were upset that the reprieve was not longer. In a December 18 statement, the American Medical Association (AMA) said it was disappointed lawmakers approved only a six-month payment fix and called on them to address the underlying problems with the physician payment formula.

> ***"While we're disappointed that the payment and grandfather provisions weren't extended for a full year, the silver lining is that it gives us another chance to stop the competitive bidding demonstration before it goes into effect."***
> ***—Alan Mertz***

"We are disappointed that [Congress] could only agree on a six-month action because it creates great uncertainty for Medicare patients and physicians," the AMA said. "We strongly urge Congress to break the tradition of short-term interventions that are not fully funded and fail to chart a course for replacing a flawed payment formula that is a barrier to improving quality and access to care for seniors."

Lawmakers told reporters December 18 that while the final Medicare package may not reflect what they initially started out to do, it was the best possible outcome, given the failure of the Finance Committee to reach agreement on a bill and White House objections to cutting managed care funding.

"The White House stopped all this," Finance Committee Chairman Max Baucus (D-MT) told reporters. "The White House stopped the tax package, the energy bill, the Medicare package from passing, and the White House stopped a significant reimbursement package for the docs. But as you get closer to the [2008 congressional and presidential elections], I don't think the White House will have quite the same power."

"This bill includes essential policies for the government to make sure doctors can continue to treat Medicare beneficiaries and to preserve healthcare services in rural areas of the country," Finance Committee ranking minority member Chuck Grassley (R-IA) said in a December 18 statement. "It's a six-month extension that serves as a stop-gap until Congress can take care of the important Medicare business that got backed up this fall."

Baucus said the Medicare package to be crafted by mid-2008 likely would be a larger bill addressing many of the provisions left out of the current agreement, such as help for low-income beneficiaries enrolled in the Medicare prescription drug program and a moratorium on Medicare reimbursement to specialty hospitals.

Stark Comments

The Senate legislation is likely to be a bitter pill for House Democrats to swallow, since they passed a massive Medicare bill earlier this year. House Ways and Means Health Subcommittee Chairman Fortney Pete Stark (D-CA) told reporters December 18 he would prefer doing nothing on Medicare this year and take up the issue next year.

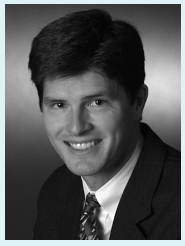
Stark said increasing doctors' pay could be done retroactively, but in any case, Congress should not fear the physician lobby.

"Your mother taught you that when a bully challenges you, if you give in, you're going to be running from them on the playground the rest of your life," he said.

The agreement also reflects the reality that Democrats are not likely to get a bill passed and signed by Bush to reauthorize the SCHIP program. Two such bills already have been vetoed by the president. Democrats had hoped to extend SCHIP funding to Sept. 30, 2008, to force Republicans to vote on the program immediately before the 2008 elections.

COMPLIANCE PERSPECTIVES

Big Changes to Physician Diagnostic Testing Under 2008 Medicare Physician Fee Schedule



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The anti-markup provisions in the final 2008 Medicare physician fee schedule final rule is likely to produce major changes in the ways physicians provide diagnostic tests. The Centers for Medicare & Medicaid Services (CMS) published the final rule in the *Federal Register* on Nov. 27, 2007 (*See* 72 Fed. Reg. 66222, 66306-66321). The changes in the final rule take effect Jan. 1, 2008. While the anti-markup provisions of the final rule are fairly straightforward, the effect of these provisions on the ways in which physician practices provide diagnostic tests cannot be overstated.

Stark Changes

In July, CMS proposed a host of changes to the Stark physician self-referral regulations as part of the proposed 2008 Medicare physician fee schedule (*see* 72 Fed. Reg. 38122, 38179-38187, July 12, 2007). With respect to many of the proposed Stark changes, CMS identified areas of concern and specifically requested comments. In some instances, CMS proposed very specific changes, and in other instances, CMS was more circumspect about the proposed fix. The Stark provisions in the proposed rule are different from (although somewhat related to) the changes in the Stark II, Phase III final rule (*see* 72 Fed. Reg. 51,012, Sept. 5, 2007). The Phase III changes are final and became effective Dec. 4, 2007.

While the anti-markup provisions of the final rule are fairly straightforward, the effect of these provisions on the ways in which physician practices provide diagnostic tests cannot be overstated.

In the final rule, CMS announced that it was deferring action on the Stark provision in the proposed rule. CMS indicated that it would finalize the following proposed changes in a separate final rule:

- Burden of proof;
- Obstetrical malpractice insurance subsidies;
- Unit-of-service (per-click) payments in lease arrangements;
- The period of disallowance for non-compliant financial relationships;
- Ownership or investment interests in retirement plans;
- "Set in advance" and percentage-based compensation arrangements;
- "Stand in the shoes" provisions;
- Alternative criteria for satisfying certain exceptions; and
- Services furnished "under arrangements."

In addition, CMS indicated that it would make any changes to the in-office ancillary services exception through a future notice-and-comment rule making, because the proposed rule did not contain a specific proposal but rather solicited comments regarding the scope and application of the exception. CMS was inundated with comments about the Stark changes it had proposed and did not have sufficient time to consider

all of the comments and make changes in the final rule. CMS did not provide any specific timeline for when it might move forward with any of the Stark changes.

Anti-Markup Changes

Although CMS did not finalize the Stark proposals in the final rule, it did finalize changes to the Medicare reassignment and anti-markup rules (collectively referred to as the anti-markup rules). The anti-markup rules are separate from the Stark rules, but they are intertwined, and CMS uses both to try to limit what CMS believes are fraudulent or unnecessary activities.

CMS originally proposed changes to the reassignment and anti-markup rules in the proposed 2007 Medicare physician fee schedule rule. CMS chose not to finalize the proposed changes to the anti-markup rules in the final 2007 physician fee schedule (PFS) final rule. Instead, based on comments CMS received on the 2007 proposed rule, CMS proposed modified changes to the anti-markup rules for 2008.

Specifically, CMS proposed to impose an anti-markup limitation to the technical (TC) and professional (PC) components of diagnostic tests. CMS explained that it was concerned that certain arrangements that on their face meet the Stark in-office ancillary services exception are not within what CMS views as the intended purpose of that exception.

CMS said it was troubled with services provided in "centralized buildings" and those where physician practices purchased or contracted for the provision of diagnostic tests. The basis for this concern appears to be the potential for a physician to realize a profit on the tests, which might then lead to overutilization resulting in higher costs to the Medicare program.

One might speculate that CMS is suggesting that the anti-markup rules only apply when using the Stark in-office ancillary services exception, as opposed to the Stark exception for personally performed services.

The proposed rule focused on whether the person performing either the TC or PC of the test was a full-time employee of the group practice, rather than a part-time employee or an independent contractor.

The final rule eliminates that distinction. It imposes the anti-markup provision on the TC and PC of diagnostic tests that are ordered by a billing physician or other supplier (or a related party) *if* the TC or PC is purchased from an "outside supplier" or *if* it is performed at a site other than the office of the billing physician or other supplier (42 C.F.R. § 414.50). An "outside supplier" is defined as someone who is not an employee and who has not furnished the TC or PC under a reassignment.

In the preamble to the final rule, CMS states that physicians can opt not to "take advantage of" the purchased diagnostic rules or the reassignment option and, instead, bill and receive payments for tests they have personally performed. Unfortunately, this statement ignores the fact that every physician in a group reassigns the right to bill and collect to the group. One might speculate that CMS is suggesting that the anti-markup rules only apply when using the Stark in-office ancillary services exception, as opposed to the Stark exception for personally performed services. The anti-markup provisions, however, are separate and distinct from the Stark regulations.

In the anti-markup rules, CMS creates a new definition for an "office of the billing physician or other supplier" without any reference to the definition of "same building" under the Stark in-office ancillary services exception. The office of the billing physician or other supplier is defined as the "medical office space where the physician or other supplier regularly furnishes patient care"(42 C.F.R. § 414.50(a)(2)(iii)).

With respect to a billing physician or other supplier that is a "physician organization," the "office of the billing physician or other supplier" is only the space in which the physician organization provides "substantially the full range of patient care services that the physician organization provides generally."

Prior to Phase II of the Stark regulations, the in-office ancillary services exception defined the "same building" to be where substantially the full range of services was provided. This terminology was stricken from the final Phase II Stark regulations and replaced with a test that looks at how many hours a week the practice is open and requires only "some" non-designated health services (DHS) to be provided at that location. By creating a new definition of "office," the *raison d'être* for the definition of "same building" under the Stark exception is made irrelevant for physician practices that perform diagnostic tests in their offices. In light of the final rule, such physician practices will need to meet the "substantially full range of services test" to avoid the anti-markup provisions.

The final rule applies the anti-markup provision to tests performed in the same building, but not in the same office space. For example, an orthopedic practice that structured its practice to provide MRI tests in compliance with the Stark in-office ancillary services exception utilizing the "same building" criteria may have located the MRI machine on the first floor of an office building and its practice on the third floor of the same building.

Under the final rule, MRI tests would be subject to the anti-markup provision because the MRI is not located in the office where the physician practice provides substantially the full range of services (even though it is the same building where the physician provides the full range of services).

Although CMS did not address such a situation in the preamble to the final rule, CMS's comments support the view that the anti-markup provisions apply to block leases. To be acceptable under Stark, a block lease must meet the in-office ancillary services exception.

Under the in-office ancillary services exception, a block lease must meet the same building criteria—the centralized building criteria will not work because a centralized building must be leased 24 hours per day, seven days per week. If the anti-markup provision applied only to "centralized buildings," but not the "same building," there would be no basis under the final rule for the anti-markup provisions to apply to block leases.

Therefore, while CMS never specifically states that diagnostic tests provided in the same building, albeit not the same office space, would be subject to the anti-markup provision, this is the practical effect of the final rule.

Therefore, while CMS never specifically states that diagnostic tests provided in the same building, albeit not the same office space, would be subject to the anti-markup provision, this is the practical effect of the final rule.

Similarly, through the anti-markup rules, CMS has vitiated the applicability of the definition of "centralized building" under the Stark in-office ancillary services exception for diagnostic tests, even though Congress expressly created a statutory exception under Stark for DHS services provided in centralized buildings.

While CMS has said it is concerned about the use of centralized buildings for diagnostic testing where independent contractors or part-time employees perform the tests that provide services to many physician practices, CMS had not previously proposed subjecting all diagnostic tests performed in centralized locations to the anti-markup rules.

In the final rule, CMS states that physicians can continue to purchase, and bill for, diagnostic tests—they just cannot profit from such tests. However, the definition of "net charge" realistically precludes most diagnostic testing arrangements that fall within the anti-markup prohibition. Not only does CMS prohibit such physicians from profiting, it potentially prohibits them from fully recouping their costs.

Under the anti-markup rules, the amount a physician practice may bill Medicare for diagnostic tests may not exceed the lowest of the following amounts:

- (i) The performing supplier's net charge to the billing physician or other supplier;
- (ii) The billing physician or other supplier's actual charge; or
- (iii) The fee schedule amount for the test that would be allowed if the performing supplier billed directly.

According to the final rule, the billed amount "must be determined without regard to any charge that is intended to reflect the cost of equipment or space leased to the performing supplier by or through the billing physician or other supplier." In addressing the calculation of the "net charge" where there is no "charge" per test (e.g., physicians performing TC or technicians are paid at a fixed rate, at a time-based amount, or a salary), CMS deferred to the billing physicians to determine a "reasonable manner" to ascertain an accurate net charge. CMS also suggested physician practices retain contemporaneous documentation of both the methodology and the information used to calculate the net charge.

Even more troubling, CMS eliminates any costs to the physician practice in providing the TC and PC of the diagnostic test in calculating the net charge. CMS refuses to prohibit the performing supplier from taking the costs of equipment or services (such as insurance) obtained from the billing supplier into account when determining its net charge in one response.

In another response, CMS states that practice administrative expenses, such as the costs of billing, could not be part of the net charge. Specifically, CMS stated that, although the anti-markup rules are not designed to prevent the physician practice from recouping overhead expenses, where a diagnostic test is performed at a location other than the physician office,

> "the billing supplier will not be able to recoup the overhead… If billing suppliers were able to recoup overhead incurred for TCs and PCs that are performed at sites other than their offices, the effectiveness of the anti-markup provisions would be undermined because there would be an incentive to overutilize to recover the overhead incurred for purchasing or leasing space."

In response to another comment requesting that CMS permit the inclusion of the costs of equipment and supplies utilized in performing the services in the net charge, CMS said doing so would be the equivalent of a "net charge plus" approach; a methodology CMS believes would defeat the purpose of the anti-markup provisions. The practical effect of the "net charge" provision is that physician practices cannot take into account the cost of equipment when billing for the TC or PC of a diagnostic test that is not performed in its offices.

Consequently, diagnostic tests not performed in a physician practice's office space may not be economically feasible. For example, if an orthopedic group owns (or leases from a manufacturer) an MRI that it locates in a "centralized building" or in the "same building," but not the same office space as the physician practice, the physician practice would not be able to include any costs related

to the MRI equipment in its net charge to Medicare for the TC. Without receiving any reimbursement from Medicare for the equipment (or for the related overhead), it is unlikely that any physician practice could afford to provide such services.

Conclusion

While the provisions that CMS chose to finalize in the final 2008 physician fee schedule rule initially appear quite simple and limited to payment rules for purchased diagnostic tests, the application of these rules in ways that CMS did not suggest in the proposed rule, or discuss in the final rule, will lead to major changes in how physicians provide diagnostic tests. Recently, CMS has hinted that it recognizes that there have been some unintended consequences of its changes to the anti-markup rules. The extent and timing of any clarification to the anti-markup rules are unclear at this time. Unfortunately, without further action by CMS, the anti-markup rules become effective Jan. 1, 2008.

Recently, CMS has hinted that it recognizes that there have been some unintended consequences of its changes to the anti-markup rules. The extent and timing of any clarification to the anti-markup rules are unclear at this time. Unfortunately, without further action by CMS, the anti-markup rules become effective Jan. 1, 2008.

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CMS Drops Mandatory Reporting for Part D, MA Plans

Health plans participating in the Medicare program will not be required to self-report potential fraud and abuse within their organizations or among their contracts, the Centers for Medicare & Medicaid Services (CMS) announced in a final rule with comment period.

Instead of mandating potential misconduct, CMS said it would retain voluntary self-reporting recommendations for Part D plans and implement similar recommendations for Medicare Advantage (MA) plans. The rule was published in the December 5 *Federal Register*.

The rule finalizes other measures the agency proposed in May, largely aimed at ramping up oversight in the Part C and Part D programs and making contract determinations. Comments to CMS on the May proposed rule had said the mandatory self-reporting requirement was too broad and too burdensome for plans.

Attorney Ankur J. Goel, with McDermott Will & Emery, Washington, says it is clear CMS intended to proceed with the requirement at some point, but that it was unclear how the mandate could be achieved. He noted that it was the third time CMS had proposed and subsequently withdrawn the mandate. Goel also said that the mandate would have been the first of its kind to require government contractors to report potential misconduct and fraud. However, he said, the concept has been under consideration in other government agencies.

CMS said it is accepting comments on the mandatory self-reporting issue until February 4.

Compliance Requirements

The final rule will require Part D and MA plans to incorporate fraud, waste, and abuse measures into their compliance plans and apply compliance requirements to contractors by January 2009. While CMS had included such requirements for Part D plans in the Medicare Rx manual, the requirement now applies to MA plans, as well.

Goel said the requirements for MA plans would affect healthcare providers because plans now were required to monitor physicians, hospitals, and other healthcare facilities for compliance with Medicare rules.

"It really reaches into relationships with providers," Goel said, saying the implication of the requirement in the MA program was broader than that in the Part D program.

CMS clarified in the final rule that it did not intend for MA and Part D plans necessarily to conduct compliance activities within each of its contractor organizations, but said compliance officers for MA and Part D plan organizations should maintain oversight of such activities.

Data Access Allowed

The rule also finalizes requirements that Part D plans include in their contract provisions that allow CMS access to any financial books, contracts, records, and other documentation from subcontractors pertinent to plans' Medicare business. Furthermore, the rule finalizes the definitions of subcontractor types—first tier, downstream, and related entities.

The effective date for the requirement to obtain access to Part D plans' contractor books and records through contractual arrangements is Jan. 1, 2009, meaning existing contracts would not be affected.

Other provisions in the final rule include changes to CMS's notification time frames for notifying Part D and MA plans of contract renewals and nonrenewals. CMS also finalized contract appeals processes and rights for plans. All such provisions are effective Jan. 4, 2008.

OIG Finds Room for Improvement in Lab Preparedness for Pandemic Influenza

Most state public health laboratories have already performed some of the tasks required by the Centers for Disease Control's (CDC) guidance on pandemic influenza, although opportunities exist to improve public health laboratory coordination with clinical laboratories, concludes a new report from the Department of Health and Human Services Office of Inspector General (OIG).

The OIG surveyed state public health laboratory officials in June about the extent to which they conducted eight critical tasks for public health laboratory testing as required by the Pandemic Influenza Guidance Supplement to the 2006 Public Health Emergency Preparedness Cooperative Agreement, Phase II.

All states reported that their public health laboratories performed the first two critical tasks, to conduct year-round influenza testing and to detect and subtype influenza viruses. Although not specifically required by the guidance, all states reported public health laboratory capability to subtype H5 influenza. The H5 subtyping test is currently only available to public health laboratories.

Consistent with this, most states reported that they have no sentinel laboratory capability to subtype H5 influenza. However, this capability may be necessary to meet increased testing needs during an H5 influenza pandemic.

All states reported that their public health laboratories did not perform at least one of the six remaining critical tasks. For the tasks involving both public health and clinical laboratories, states reported performing the required activities for public health laboratories to a greater extent than for clinical laboratories.

The report is available at *www.oig.hhs.gov/oei/reports/oei-04-07-00670.pdf*.

CMS Establishes Liability Standard for MIPs

Entities contracting with the Centers for Medicare & Medicaid Services (CMS) to conduct audits and other anti-fraud and abuse activities under the Medicaid Integrity Program (MIP) will have civil and criminal liability protections if they perform those duties with due care, under provisions in a final rule published in the *Federal Register* November 30.

The rule explains that, although CMS received a comment expressing concern that the due care standard "cannot sufficiently ensure" so-called Medicaid Integrity Contractors (MICs) are "adequately held accountable for their actions," the standard is required under provisions in the Deficit Reduction Act (DRA).

"Section 1157 of the Act limits a contractor's liability under a due care standard," the agency said. "We believe that applying this standard to the MICs strikes a reasonable balance between the concerns of the contractors and those subject to the contractors' review. We further believe the MICs will operate with due care to avoid liability, and those being reviewed have the assurances that they have legal recourse if a contractor fails to abide by that standard."

CMS said it had considered using a gross negligence standard to protect contractors from civil liability, but that it was held to the stipulations under Section 1157. Further, the final rule is consistent with Medicare Integrity Program standards.

The final rule on "Medicaid Integrity Program; Limitation on Contractor Liability" goes into effect on Dec. 31, 2007.

Contractors' Role

The DRA established the Medicaid Integrity Program, which CMS said is its first comprehensive national strategy to ensure the proper use of Medicaid funds and prevent fraud and abuse. CMS launched the program on July 18, 2006, with $5 million in funding for 2007. The amount is set to rise to $75 million by fiscal year 2009 and each year thereafter.

The act authorizes the secretary of the Department of Health and Human Services to enter into contracts with entities that are to perform the following duties:

- Review the actions of providers and others seeking Medicaid payments under a state plan or waiver to determine whether fraud, waste, or abuse has occurred or is likely to occur and if Medicaid expenditures are used in a manner not intended;
- Audit claims for payment for items or services provided or administrative services under a state plan;
- Identify overpayments of individuals or entities receiving federal funds; and
- Educate service providers and beneficiaries about payment integrity and quality of care.

The proposed rule was issued July 20, and the only comment by the end of the public comment period was from a healthcare association, CMS said. The final rule addressed submitted concerns about whether MICs would have knowledge of state-specific payment methods and the need for CMS to make information about the contractors available to the public.

CMS responded that it is working with strategic contractors to develop states' program integrity profiles and to develop audit standards for MICs to use. Further, the agency said it is working with state Medicaid Directors, Medicaid Fraud Control Unit directors, and other state and federal partners in program planning and in making information about it available. Such information can also be accessed on the CMS Web site, it said.

OIG Okays 'Preferred Hospital' Arrangement as Part of Medigap

A proposed arrangement to use a "preferred hospital" network as part of a Medicare Supplemental Health Insurance (Medigap) policy would not constitute grounds for imposing civil money penalties, the Department of Health and Human Services Office of Inspector General (OIG) concludes in a new advisory opinion (No. 07-15), posted December 10.

In addition, while the Medigap plan could potentially generate prohibited payments under the anti-kickback statute, if the requisite intent to induce or reward referrals of federal healthcare program business were present, the OIG said it would not impose administrative sanctions. The Medigap plan would indirectly contract with hospitals for discounts on the otherwise applicable Medicare inpatient deductibles for its policyholders and would also, at the time of the next policy renewal, reduce the premium for policyholders using a network hospital for an inpatient stay.

The unnamed requestor proposed to contract with one or more preferred provider organizations (PPOs) for inclusion of its policyholders in the PPOs' hospital networks across the country. Under the arrangements, the requestor would receive a discount of up to 100% on Medicare inpatient deductibles, which would otherwise be covered by the Medigap plan, incurred by its policyholders at network hospitals.

Part A Application

The arrangement would apply only to the Part A inpatient hospital deductible and not to any other coinsurance or cost-sharing amounts. To promote use of the network, the requestor will return a portion of the savings directly to any policyholder that has an inpatient stay at one of the participating hospitals—a $100 credit off of their next renewal premium.

The requestor would pay the PPO a fee for administrative services and, if a policyholder is admitted to a non-network hospital, the requestor would pay the full Part A hospital deductible as provided under the Medigap policy.

The OIG determined that the proposed arrangement is a straightforward agreement by the PPO network hospitals to discount the Medicare inpatient deductible for the requestor's policyholders. The safe harbor regulation for waivers of inpatient deductibles specifically excludes such waivers when they are part of an agreement with an insurer, such as the requestor, the OIG found.

In combination with Medigap coverage, the discounts offered on inpatient deductibles by the network hospitals present a low risk of fraud or abuse, the OIG determined. The waivers will not increase use, since the discounts will be invisible to patients and the patients have already purchased supplemental insurance to cover the obligation, the OIG said.

The advisory opinion is available at *www.oig.hhs.gov/fraud/docs/advisoryopinions/2007/AdvOpn07-15A.pdf*.

Lab Settles False Claims Charges: Dianon Systems Inc., a laboratory based in Stratford, Connecticut, has agreed to a $1.5 million civil settlement with the federal government to resolve allegations that the company submitted false claims to Medicare and TRICARE for certain diagnostic tests, according to the Department of Justice (DOJ). The government claimed Dianon billed the federal healthcare programs for flow cytometry services that were medically unnecessary or that were never rendered. The case was initiated in 2002 by whistleblower James Tiesinga, a physician who had worked as a pathologist for Dianon from July 2001 to June 2002. Dr. Tiesinga will receive $300,000.

Insurers Agree to Model Standards: Two additional large health insurance plans have agreed to settlements requiring them to adhere to model standards for physician ranking programs, according to New York Attorney General Andrew Cuomo (D). With the latest settlements, reached with United Healthcare and the combined Group Health Inc. and Health Insurance Plan of New York, five insurers have adopted the reforms. United, the second largest U.S. health insurer, will apply the model standards nationally, as will CIGNA Health Care, Aetna, and Wellpoint, the parent of Empire Blue Cross Blue Shield.

Hospital Settlement: A New Jersey hospital has agreed to pay the United States $7.5 million to resolve allegations it defrauded Medicare, the Department of Justice said December 10. The DOJ alleged that between 1999 and August 2003, Warren Hospital (Phillipsburg, NJ) purposefully inflated charges for inpatient and outpatient care to make these cases appear more costly than they actually were, and thereby obtained outlier payments from Medicare that it was not entitled to receive. The settlement agreement also resolves claims that the hospital violated the Stark law, which prohibits claims for Medicare patients referred by physicians with whom a hospital has an unlawful financial relationship.