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### Exclusion of Providers to Be More Popular Tool Under Medicaid; DRG Is Top Target

States will be excluding more individual and institutional providers as part of their crackdown on Medicaid fraud and abuse. The goal is to identify poor performers so Medicaid doesn’t waste money on inadequate care and put people at risk of harm.

“You will see an increased use of exclusion authority,” attorney Frank Sheeder, who is with the law firm of Jones Day, said in a Jan. 23 audioconference sponsored by the Health Care Compliance Association. “Around the country, you will see a more liberal use of exclusion authority by the regulators.”

New York is one of the states that plans to do “a lot more exclusions,” says Jim Sheehan, the Medicaid Inspector General for New York. “Many states have more exclusion authority than the feds.” Poor quality of care will drive a lot of the exclusions. “If you are unable to provide the minimum quality necessary, you will be out of the program,” Sheehan said in the audioconference and an interview with MCN.

For example, New York, like many states, has Medicaid conditions of participation that are similar to Medicare’s. Violating them will increasingly result in penalties, including false claims lawsuits and Medicaid exclusion, according to Sheehan. “That’s a trend I expect to see around the country. I expect to see more and more [conditions of participation cases] handled through program integrity offices,” he says.

*continued on p. 10*

### Pennsylvania Nursing Home Facing Medicaid Fraud Charges Enters Into Consent Order

A Pennsylvania nursing facility for medically fragile children, which was sued by federal and state agencies for Medicaid fraud and failing to comply with state licensing requirements, entered into a consent order Jan. 22 with the U.S. District Court in Philadelphia, agreeing to bring in a temporary outside manager for its three facilities. This is despite the fact that it disputes the allegations and argues that it complied with state licensing requirements for residential skilled nursing facilities.

Under the terms of the consent order, Holland-Glen will retain Cambridge Horsham Pediatrics LLC as temporary manager of its three facilities in suburban Philadelphia, will comply with quality-of-care standards contained in federal nursing facility regulations, and will continue to be monitored by the current court-appointed monitors. Moreover, Holland-Glen’s chief executive, William Schlachter, and its board of directors have consented to have no role in the management or oversight of the facilities.

The consent order also contains a letter of intent concerning the potential transfer of Holland-Glen’s assets to Cambridge. If Holland-Glen does transfer assets to Cambridge, the consent order requires approval by the Pennsylvania Department of Public Welfare (DPW). And it further requires that Cambridge comply with the quality-of-care standards contained in the federal nursing facility regulations. In the event of a transfer,
the court-appointed monitors will monitor the care provided in Cambridge facilities for three years.

The U.S. Attorney’s Office, along with the state DPW, filed a complaint against Holland-Glen in June 2007. The complaint alleged that the facility defrauded the federal and state governments by providing substandard nursing care or failing to provide nursing care at all and then billing Medicaid as if proper care had been provided.

According to the complaint, despite promising to provide skilled nursing services to residents, Holland-Glen did not apply for a license from the state to operate a nursing facility. It has license to operate only as a community group home for mentally retarded persons, the complaint says.

The complaint alleges that Holland-Glen falsified resident medical records and records of billing, failed to comply with generally accepted standards of care relating to pain management and assessment, failed to check backgrounds of its employees and failed to provide proper general-resident care.

It includes allegations of substandard care in the form of Holland-Glen’s failure to respond to respiratory alarms, failure to comply with physician orders for pulse oximeters, failure to prevent severe bed sores and failure to administer medications properly.

David Moffit, an attorney with the law firm of Saul Ewing LLP who is representing Holland-Glen, tells MCN that “Holland-Glen has consistently denied the allegations in the complaint.”

In fact, he says, the two court-appointed monitors who inspected the facilities last summer “found the quality of care at the facility to be acceptable in all material respects.” “Every medical professional that has evaluated quality of care at the facility since 2005...has found the care to be acceptable in all material respects,” he adds.

According to Patty Hartman, a spokesperson for the U.S. Attorney’s Office, the monitors’ reports are not public information as of now.

With regard to the allegations of improper licensing, Moffit says that “Holland-Glen held the most appropriate license available from DPW.” He asserts that “every other facility in Pennsylvania caring for a similar population of vent-dependent children is similarly licensed.” He adds that the DPW “has no quality of care regulations and...is in the process of addressing this gap in its regulatory coverage.”

Unfortunately, says Moffit, “Holland-Glen is a nonprofit [organization] without the resources necessary to defend the government’s lawsuit. Even though we [are] confident that Holland-Glen would have prevailed at a preliminary injunction hearing, the only viable option was to settle and transfer the business.”

Contact Moffit at dmoffit@saul.com. ♦

State Medicaid Program Adopts Rule on Preventable Adverse Errors

Pennsylvania instituted a new policy effective Jan. 14 under which hospitals will not receive Medicaid payments under the state’s medical assistance program for certain preventable serious adverse events. The policy was implemented by Gov. Edward Rendell (D) as part of his health care reform plan, “Prescription for Pennsylvania” and will have a significant impact on hospitals, which could face penalties for noncompliance (MCN 11/07, p. 1).

The policy also follows the lead of CMS and its Medicare policy. Effective Oct. 1, 2008, CMS will restrict Medicare reimbursements to hospitals for eight conditions that are considered hospital-acquired, in accordance with a Deficit Reduction Act mandate. According to CMS, this rule is designed to improve patient safety. And at least one
The Domino Effect

Other state hospital associations are also following CMS’s Medicare policy of cracking down on preventable errors. According to the Massachusetts Hospital Association, effective in early 2008 all Massachusetts hospitals will adopt a uniform policy of not billing for certain serious adverse events as defined by the National Quality Forum (NQF).

The policy covers nine serious adverse events:
- surgery on the wrong body part;
- surgery on the wrong patient;
- retention of foreign object;
- wrong surgical procedure;
- incompatible blood-associated injury;
- air embolism-associated injury;
- medication error injury;

State Will Review Billing

Under Pennsylvania’s new policy, issued to general acute care hospitals in Department of Public Welfare Medical Assistance Bulletin 01-07-11, the state Medical Assistance program will review billing for various preventable errors, including operating on the wrong patient, medication errors resulting in death or disability, and bad blood transfusions. The program will deny payment when it determines that the event was preventable, it was within the control of the hospital, it occurred during an inpatient hospital admission, and it resulted in significant harm.

According to the bulletin, the Medical Assistance program will generate a monthly report identifying claims submitted with ICD-9 diagnosis codes or external cause of injury (E) codes that might indicate the occurrence of a preventable serious adverse event.

For those claims, hospitals must submit the Medicaid recipient’s entire inpatient medical record to the program for review within 30 days of the request. If a hospital fails to submit requested medical records, it may be subject to administrative sanctions, including payment denial or restitution in relation to the hospital stay, the bulletin says.

The policy was developed by the Pennsylvania Department of Public Welfare, in collaboration with the Hospital and Healthsystem Association of Pennsylvania (HAP), which voiced support for the policy. “Hospitals recognize that preventable serious adverse events can have a profound effect on patients,” said Paula Bussard, senior vice president for policy and regulatory services at HAP. “This policy represents another important step in Pennsylvania hospitals’ efforts to provide the best possible care to each person who comes through our doors.”

“We think that this new policy provides guidance for hospitals and the Medical Assistance program that will assure that payments are made to hospitals for medically necessary services, and not made when preventable serious adverse events occur during a hospitalization,” she added.

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✔ Report on Research Compliance, a monthly newsletter, weekly e-letters and subscriber-only Web site on conflict of interest, human subjects, scientific misconduct, tech transfer and much more; copublished by NCURA.
✔ A Guide to Auditing Health Care Billing Practices (updated monthly with news summaries), a comprehensive looseleaf with step-by-step guidance on one of the most complex big-dollar issues in Medicare compliance.
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artificial insemination/wrong donor error; and
infant discharged to the wrong family.

Lynn Nichols, president and CEO of the Massachusetts Hospital Association, says that the initial policy will address the nine events listed above, but it will ultimately “expand the list of serious adverse events that should not occur and for which hospitals should not charge.”

Now, according to the association, if a serious adverse event does occur in a hospital in Massachusetts, the hospital discloses the incident and apologizes to the patient. Then the hospital reports the incident to the Department of Public Health and the Board of Registration in Medicine.

Minnesota says it is taking an even tougher stance against preventable errors, and claims it is the “first” state to unveil such a billing policy. In September 2007, Minnesota Gov. Tim Pawlenty (R) announced that Minnesota had established a statewide billing policy for care made necessary by adverse health events.

Under the policy, hospitals in Minnesota cannot bill for 27 types of reported adverse health events defined by NQF, including wrong-site surgeries, serious medication errors and objects left inside a patient during surgery.

The state already requires hospitals, surgical centers and behavioral health hospitals to publicly report any occurrence of these adverse health events.

Most recently, Gov. Chris Gregoire (D) said Jan. 29 that the Washington State Hospital Association, Washington State Medical Association, and Washington Ambulatory Surgery Center Association have voluntarily adopted a resolution to not charge for care related to serious medical errors. The resolution covers 28 specific adverse events, including wrong-site surgery, death or serious disability from malfunctioning devices or falls, and serious ulcers of the skin.

Contact Bussard through the HAP communications department at (717) 561-5378 and Nicholas through MHA spokesperson Rich Copp at (781) 272-8000, ext. 161.

Medicare Center Settles Lawsuit Alleging Unnecessary Procedures

Lafayette General Medical Center (LGMC) in Louisiana will pay a $1.9 million civil fine to resolve allegations that it defrauded state and federal health care programs by billing for medically unnecessary angioplasties procedures between 1999 and 2004. “LGMC knew — from reports of hospital employees and from reports generated by its own internal review processes — that a physician was performing unnecessary procedures at its hospital yet deliberately failed to address the problem,” the feds say in a Jan. 11 prepared statement.

Whistle-blower Alleges Inappropriate Procedures

The case stems from a whistle-blower suit filed by Christopher Mallavarapu, M.D., a cardiologist who alleged that “another cardiologist was routinely endangering the health and safety of patients by subjecting them to unnecessary and inappropriate medical procedures,” the feds explain.

Gordon Rountree, LGMC’s general counsel, says the hospital settled to avoid the uncertainty and cost of litigation. LGMC did not admit guilt or liability in the settlement, he adds. “This is a matter that had been open since 2003, and it took the DOJ [i.e., Department of Justice], OIG and LGMC a while to conclude it,” Rountree says.

“LGMC has diligent compliance procedures in place to ensure that all the procedures that are performed are medically necessary.”

The cardiologist under indictment no longer performs procedures at LGMC and has been off the medical staff for several years, Rountree says. The other hospital in town where this physician primarily practiced settled with the DOJ-OIG more than a year ago for $3.8 million, he tells MCN.

An August 2006 prepared statement from the feds says that Our Lady of Lourdes Regional Medical Center agreed to pay $3.8 million to settle allegations that it submitted Medicare and Medicaid claims for unnecessary cardiac procedures performed by Mehmood Patel, M.D.

Patel was indicted in March 2006 on 94 counts of health care fraud. “The indictment alleges that Patel performed unnecessary procedures, some of which caused serious harm to the affected patients,” the U.S. attorney’s office said in a statement. He owned Acadiana Cardiology, LLC and performed procedures at LGMC and Lourdes, the feds said. The feds say he defrauded public and private health plans of about $2.5 million.

Patel’s case may bring back memories of events at Redding Medical Center in California, which settled with the feds for $54 million in 2003 to resolve allegations that two cardiac surgeons performed unnecessary open-heart surgeries. The physicians, Redding and the company that owns the hospital, Tenet Healthcare Corp., all denied the allegations, and the physicians never had criminal charges brought against them.

The feds allege that the hospital billed Medicaid and Medicare for medically unnecessary elective angiograms, angioplasties and stent procedures between 1999 and 2004. “LGMC knew — from reports of hospital employees and from reports generated by its own internal review processes — that a physician was performing unnecessary procedures at its hospital yet deliberately failed to address the problem,” the feds say in a Jan. 11 prepared statement.

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But Patel faces criminal charges and 20 years in prison if he is found guilty. His lawyers did not respond to a request for comment by MCN press time.

**Hospitals Should Be Diligent**

“To successfully discharge their basic obligations to patient safety, hospitals must create and follow reasonable processes as the gatekeeper for safeguarding patients from unscrupulous practitioners who would harm them during their hospital stay,” the feds say in comments about the LGMC settlement.

If there are noticeable statistical anomalies in the number of procedures performed at a hospital, “a warning bell should sound to hospital administrators,” says Michael Hirst, who was the lead federal prosecutor in the Redding Hospital case.

“Hospitals should have credible and substantial peer-review systems in place. Other physicians should be able to express concerns about unnecessary procedures without fear of retribution. If appropriate, outside experts should be consulted,” he says.

“In the past, whistle-blowers and the government have shied away from medical-necessity fraud cases, including allegations of unnecessary procedures. The concern was that fraud is difficult to prove when the testimony devolves into a battle of the experts,” says Hirst, who now has his own firm, Hirst & Chanler, LLP. “Defendants will find other doctors to testify that the procedures, while perhaps ‘aggressive,’ were not patently unreasonable. As

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**High Amount of Improper Medicaid Payments Will Lead to Increased Scrutiny, Enforcement**

The Medicaid program reported improper payments for fiscal year (FY) 2007 totaling $12.9 billion, according to a Jan. 23 report by the Government Accountability Office (GAO). This report, along with the high preliminary national Medicaid error rate of 18.5%, will cause “lots of sparks on the Hill,” says one observer.

The GAO report, “Improper Payments: Federal Executive Branch Agencies’ Fiscal Year 2007 Improper Payment Estimate Reporting,” is based on audits of the improper payments reported by federal executive branch agencies in their FY 2007 performance and accountability reports (PARs) or annual reports. Of the 30 agencies reviewed, 21 agencies reported improper payment estimates in their PARs, and eight agencies reported that they did not have any programs or activities susceptible to significant improper payments.

The largest improper payment estimate was related to HHS’s Medicaid program, with estimated improper payments of approximately $13 billion.

Former Texas Medicaid Inspector General Brian Flood says Sens. Charles Grassley (R-Iowa) and Max Baucus (D-Mont.) will see a very big number of improper payments and a very high error rate under the Payment Error Rate Measurement (PERM) program and regard this as an opportunity to go “fishing around for what they can do to fix” this “validated problem.”

The feds will call over to CMS, which already has projects in place to reduce the payment error rate, says Flood, who is now national managing director for consulting firm KPMG LLP. This report will bring “increased scrutiny” to the problem and “increased support [to CMS] from the Hill,” he says.

Under the Improper Payments Information Act of 2002, CMS must annually review and estimate the amount of improper payments identified for Medicaid and the State Children’s Health Insurance Program. To meet this requirement, CMS implemented the PERM program, under which CMS will conduct reviews in three areas of Medicaid and SCHIP programs: fee-for-service, managed care, and program eligibility. The agency will use the results of these reviews to produce both national and state-specific error rates. States are measured once every three years.

The preliminary results from the PERM program indicated an 18.5% error rate for the first two quarters of FY 2006 (MCN 12/07, p. 3).

Increased scrutiny from Congress will lead to increased pressure on the states to collect the correct payments from providers and increased pressure on providers to comply, Flood adds. “Auditors will hit the road with a clear message to go get the money,” he tells MCN.

So what can providers do? Flood suggests that providers start “looking to take proactive steps to determine what their risk [for payment errors] is” and what they can do to prevent [a high rate]” before the auditors come knocking.

such, the case can start to resemble a medical malpractice action more than a fraud prosecution.”

“But I think the government and private counsel are becoming more willing to take on these cases,” he adds. “If the evidence is there, the defense experts will be discredited. And the allegations often present significant patient safety issues. They certainly have jury appeal. Beyond other False Claims Act cases in which the government has been defrauded, these cases can cause doctors’ and hospitals’ reputations to take a tremendous hit. I think that’s true whenever patient safety is implicated.”


As Moratorium Nears End, Providers Face Losses; Bush Changes Kick In

Hospitals and other providers already are facing the loss of funds to overpayment recoupment from the multiple Medicaid auditors knocking at their doors or on their way—from the HHS Office of Inspector General (OIG), Medicaid Integrity Contractors, Payment Error Rate Measurement and state Medicaid auditors. But they will also have to cope with payment cuts from the Bush administration that will soon take effect unless Congress again runs interference.

CMS issued a series of regulations over the past year that ultimately will slash payments, says Washington, D.C., attorney Charlie Luband. It’s a one-two whammy for providers: the Bush administration reductions along with money shelled out by audit and compliance staff to address the presence of Deficit Reduction Act-funded auditors and the overpayment returns likely to flow from them. “In sum, the administration is attempting to substantially narrow the Medicaid program,” he says.

So far, there has been a reprieve. The payment changes haven’t been implemented yet because Congress came to the rescue with a moratorium, says Luband, who is with the law firm of Ropes & Gray.

One moratorium, enacted last May (H.R. 1591), blocks CMS from finalizing many of the payment changes. However, some changes, in particular changes cost-limiting Medicaid payments to governmental providers, are poised to take effect the minute the moratorium expires in May because CMS issued final rules between the time that Congress passed the legislation containing the moratorium and the time that Bush signed the bill.

If it seems confusing that Bush signed legislation containing a moratorium forbidding rules that his administration advocates, it’s only because larger, more pressing issues were at stake in the legislation. The president also signed a bill containing another moratorium delaying additional Medicaid rules in December (S. 2460).

Here are some of the payment changes and the dates to which they are delayed because of the moratoria, according to Luband and the American Public Health Services Association. Rules that are already final take effect immediately after the expiration of the moratorium. The rules that are still proposed will require CMS action before they can be effective:

- **Cost limits** (72 FR 2236; 72 FR 29748): CMS published a final cost-limit rule in May 2007. It bars Medicaid from paying more to governmental providers, such as county nursing homes and many public hospitals, than the cost of serving Medicaid patients. “Government providers won’t be permitted to make any margin on a Medicaid patient,” he says. “Some margin is always necessary to allow adequate reinvestment. The rule doesn’t provide for this, and since the government providers most affected by this rule often [lack] any margin to help offset the cost of serving uninsured patients, there will be a huge adverse impact on the health care safety net.”

A moratorium suspended implementation until May 25, 2008. CMS contends this policy change is necessary, citing abuse with intergovernmental transfers. Counties and other local governmental units use intergovernmental transfers to contribute to the state share of Medicaid, which is jointly funded by the states and federal government.

For years, CMS has claimed that some states abuse intergovernmental transfers by forcing governmental providers to send payments back to the state and “recycling” these funds. “However, CMS has already effectively clamped down on these abuses, and the new rule primarily harms providers and the patients they serve,” says Luband.

- **Graduate medical education** (72 FR 28930): CMS proposed a rule that eliminated Medicaid’s ability to fund graduate medical education (GME). When the moratorium ends and the final rule takes effect, hospitals would no longer be able to receive Medicaid GME payments for training residents. The moratorium delayed any further action on the proposal until May 25, 2008.

- **Rehab services** (72 FR 45201): CMS proposed a rule in August 2007 to restrict rehabilitative services that can be provided under Medicaid. This was delayed by the congressional moratorium until June 30, 2008, according to the American Public Health Services Assn.

- **Hospital outpatient services** (72 FR 55158): This proposed rule narrows the definition of outpatient services and modifies how the upper payment limit is calculated. Finalized last September, it could significantly reduce payments, according to Luband.

- **Provider tax** (72 FR 13726). Although this proposed rule makes some changes mandated by Congress in the
Tax Relief and Health Care Act of 2006, the rule makes additional changes that will substantially tighten certain standards related to provider taxes, thus making them less attractive to states. The implication for health care providers is to place additional barriers on states’ use of provider taxes to finance provider payments.

“Particularly given tax revenue reductions at the state level as a result of the slowing economy, all of these regulatory changes are likely to result in substantial provider cuts,” says Luband.

“Some payment cuts may take effect in late spring, early summer.” Luband advises hospitals to start preparing for these payment cuts. “If you need to start planning for severe reductions in payments from Medicaid, you need to start planning now,” he asserts.

Luband also suggests providers work with their states to see what’s possible in terms of averting some payment reductions. For example, some of the changes — such as the cost-limit rule — affect only governmental hospitals, so Luband suggests public hospitals consider an analysis of the pros and cons of relinquishing government status. The pros may outweigh the cons. In addition, Luband recommends that providers work with their states and national associations in lobbying at the federal level to halt the rules from going into effect.

Contact Luband at Charles.Luband@ropesgray.com. ♦

New Form 990 Brings Scrutiny of Hospital Compliance, Governance

Nonprofit organizations — particularly hospitals — will have to provide more detailed information about compensation on the new IRS Form 990, which the IRS recently unveiled for tax year 2008. The IRS is paying unprecedentedly closer attention to governance and hospital operations, and this information is viewed as a great source for Medicaid enforcement, experts say.

For the first time, there is a Medicaid and Medicare element to the 990 form, requiring greater vigilance on the part of nonprofit hospitals. The IRS wants to know whether hospitals have written policies for whistleblowers and conflicts of interest, and the nature of joint ventures (e.g., with for-profit organizations), says Beth Essig, an attorney with the law firm of Epstein, Becker & Green. “This is information that can be used by other regulators,” she says, such as CMS, the HHS Office of Inspector General, and state Medicaid auditors.

Under most state Medicaid program rules, when a provider buys goods and services from a related party (e.g., a vendor owned by the hospital, a durable medical equipment company owned by a home health agency or family member of the health agency), the provider can seek Medicaid reimbursement only for the costs of the goods and services, said Brian Flood, a national managing director for consulting firm KPMG LLP and former Texas Medicaid inspector general (MCN 12/07, p. 1).

Now, with the 990, Medicaid auditors will be able to cross-check information on the form against Medicaid costs and reports and other available databases to identify inappropriate related-party profits, he said.

Also, with the new 990, hospitals will have much more of an opportunity to put their charitable activities in context. Unlike the current 990, the new 990 allows hospitals to use narrative form in multiple locations to explain the various ways they assess the needs of the community and provide community benefit, says Houston attorney Todd Greenwalt, who is with the law firm Vinson & Elkins.

The 990 is the form used by nonprofits to report information to the IRS on their charitable and other activities. It’s the IRS’s primary tax compliance tool for nonprofits. Greenwalt notes that the form serves both a transparency purpose and an enforcement purpose. “The new 990 is more comprehensive and more intrusive because it asks for considerably more information than was requested about the old form,” he says.

Completing the form should not be left to the finance department, Essig says. It calls for a team effort involving compliance, public relations, senior executives and others, because the information inside is potential dynamite, according to Essig. Once reported in the public domain, the 990 can affect operations and public relations, such as fundraising and patient perception. For example, how many donors will open their wallets for hospitals that pay 100 employees more than $100,000 each? Or what will be

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the effect on the public when the local newspaper reports that the CEO of a local hospital earns $1 million, she says.

The hospital schedule will be phased in, Essig notes. “There is a one-year breather for [hospitals] to go back and look at their charitable care and community benefit activities so when they must be disclosed in 2009, they are ready to disclose information they are comfortable with,” she says.

According to the IRS, only the portion of Schedule H that provides certain identifying information regarding hospital facilities must be completed for 2008. The other portion of the schedules will be optional for 2008. Schedule H becomes fully implemented in the 2009 tax year.

**Detailed Information to Be Provided**

All nonprofits must fill out the “core” Form 990 (Parts I through XI), and hospitals must also complete Schedule H.

Essig and Greenwalt agree that hospitals should focus on three areas in particular — questions on compensation, governance, and charitable activities.

The area that perhaps has nonprofits the most nervous is executive compensation, which can look bad splashed across a newspaper.

The 990 for the first time asks how many people earn more than $100,000 in reportable compensation, Essig says.

It also tries to catch severance payments by asking for information on former executives and officers. And there are some details about indirect compensation. For example, did the tax-exempt organization provide first-class travel to any of the first highest-paid executives or their companions?

“The IRS didn’t ask this level of detail before,” says Greenwalt.

Moreover, the same executive compensation questions remain from the existing 990. Nonprofits must reveal the compensation of all current and former officers and directors, including the CEO, as well as a list of the compensation of the five highest-paid non-officers who make more than $100,000.

Beyond sheer numbers, the 990 requires details on how hospitals set compensation, and this is a significant development because a hospital’s answers can make or break it audit-wise, Greenwalt says. Do they use compensation surveys and consultants?

Two hospitals may each pay their CEO $1 million, but it’s “a red flag” if one didn’t consult with any experts while the other convened a committee that hired a consultant and used survey data to set compensation, and the $1 million is at the 80th percentile for executive compensation, explains Greenwalt. In that case, the IRS may say that the hospital is putting in a lot of effort to ensure compensation is reasonable, so it is not an audit target, he says.

Nonprofit hospitals also are subject to fines for failure to provide the 990 in a timely manner. The fine is $20 for every day, up to a maximum of $10,000 per return. Moreover, a $5,000 penalty for “willful failure” may be applied.

View the new form at www.irs.gov/eo. Contact Essig at bessig@ebglaw.com and Greenwalt at tgreenwalt@velaw.com. ♦

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**Compliance Resources From HCCA**

- **A Supplement to Your Deficit Reduction Act Compliance Training Program.** This 13-page handbook offers an easy way to educate your employees about the basics of Medicare and Medicaid, the Federal False Claims Act, and the whistleblower protections that help health care workers fight fraud.

- **Bridging the Gap Between Medicare Compliance and Medicine.** This 12-minute video offers a simple way for compliance officers to highlight the importance of Medicare compliance to physicians. Topics include making sense of Medicare language, understanding Medicare’s covered-services approach, identifying Medicare’s areas of flexibility, and more.

- **Guide to Resident Compliance Training.** This guide offers a complete training program designed to introduce resident physicians to key compliance concepts, including ethics, coding and reimbursement, conflicts of interest, HIPAA and confidentiality, human subject research, fraud and abuse, and more.

- **Compliance 101, Second Edition.** This guide offers a comprehensive review of health care compliance fundamentals, including the seven essential elements, the steps needed to set up and maintain an effective program, sample policies and procedures, and more.

- **Health Care Auditing & Monitoring Tools.** This toolkit provides more than 100 sample policies, procedures, guidelines and forms to help establish or enhance your compliance auditing and monitoring efforts. Materials assist with risk assessment and plan development, conducting and reporting audits, evaluating program effectiveness, and more.

Visit the HCCA store at www.hcca-info.org, or call 888-580-8373.
Massachusetts recovered $26.7 million in settlements and judgments for more than 60 Medicaid fraud cases in 2007, according to Attorney General Martha Coakley (D). According to Coakley, this is the largest amount of Medicaid dollars recovered by the attorney general’s office since the creation of the attorney general’s Medicaid fraud division in 1978. The single largest Medicaid fraud recovery in 2007 stemmed from a case against Rolling Throne, a motorized wheelchair mobility company, resulting in a $8.15 million settlement. Go to http://www.mass.gov/?pageID=cagohomepage&L=1&L0=Home&sid=Cago.

A Champaign County court has dismissed the antitrust lawsuit filed by the Illinois Attorney General Lisa Madigan (D) against two clinics for allegedly agreeing to boycott new Medicaid patients seeking primary medical care. Madigan filed suit in June 2007, alleging that Carle Clinic Association, P.C. and Christie Clinic, P.C. illegally agreed to stop accepting new Medicaid patients and to limit the medical services to Medicaid-eligible patients in an effort to increase their Medicaid reimbursement rates and to accelerate reimbursement payments from Illinois. The case was dismissed Jan. 17, but the ruling allows Madigan to address the problems identified in the complaint and refile it within 30 days. Visit http://www.ccircuitclerk.com/ to view the court documents.

The former owner of a Houston-based medical equipment and supply company has been sentenced to 10 years of probation after pleading guilty to first-degree felony theft, said the Texas attorney general’s office. Samuel Edem owned the now-defunct Semeds Medical Equipment and was arrested for billing Medicaid for incontinence supplies, such as adult diapers, that he never delivered. In addition to probation, he was sentenced to 240 hours of community service and must repay more than $80,000 he admitted stealing from the Texas Medicaid program. Go to www.oag.state.tx.us.

The former owner of a motorized wheelchair company was indicted on two counts of Medicaid fraud, according to the New Mexico attorney general’s office. The attorney general’s office alleged that Israel Keppel, who owned Rolling Throne and is general manager of Right Track Mobility, Inc., submitted false billing to the New Mexico Medicaid program for the construction of a metal wheelchair mobility ramp in 2005. Each count of fraud is a fourth degree felony, punishable by 18 months in prison and/or a $5,000 fine. Keppel did not respond to a request for comment by MCN press time. Visit www.nmag.gov.

Two owners and one employee of a home health care agency were indicted on two counts each of second-degree health care claims fraud and third-degree Medicaid fraud for submitting nearly $1 million in fraudulent bills to the New Jersey Medicaid program, said the New Jersey attorney general’s office. The indictment alleges that Touch of Life Home Health Care Agency, LLC billed Medicaid for personal care assistant services that were rendered at Class C boarding homes and residential health care facilities. Medicaid regulations do not permit billing for personal care assistants and home health aides’ services in Class C boarding homes and residential health care facilities because such facilities are already paid by the state for personal care services administered to the residents. The indictment also alleges that Touch of Life billed the Medicaid program for 6,946 hours of personal care assistants and related services more than were actually provided. If convicted of Medicaid fraud, the defendants face a maximum of three years imprisonment and a criminal fine of $10,000. Go to www.nj.gov/oag.

The Florida Medicaid Fraud Control Unit has recovered a $458,000 civil settlement for false Medicaid claims against a Palm Beach County company, the attorney general’s office said Jan. 30. Palm Beach Transportation, Inc. is alleged to have used the names of Florida Medicaid patients to create false trip tickets to submit to the state Medicaid program. In turn, the attorney general’s office alleges that the program reimbursed the company for transportation never provided. The state MFCU reviewed company records from 2003 through March 2004 and found evidence that the company was paid $423,000 for the alleged false claims during that period. Under the settlement, the company must fully reimburse the state and pay $35,000 for fees and costs under the Florida False Claims Act. Visit http://www.myfloridalegal.com/.
CMS Ends Payments for School Activities Susceptible to Fraud

CMS has issued a final rule eliminating the federal Medicaid payment for the costs of certain school-based administrative and transportation activities, citing concerns of improper billing by school districts for administrative costs and transportation services under the shared federal/state Medicaid program.

According to the agency, schools in some states have claimed more federal dollars for administrative costs than for the actual Medicaid services provided to beneficiaries. These expenses include capital costs, transportation of children to and from school even when the children received no medical services, and school officials’ salaries and fringe benefits. Thus, the agency has determined that federal Medicaid payments will no longer be provided for claims of administrative activities performed by school employees or contractors, or anyone under the control of a public or private educational institution, or for transportation from home to school.

The rule does not affect federal reimbursement for direct medical services provided by schools for children who are Medicaid beneficiaries such as physical therapy, speech therapy or transportation to medical services during the school day, said the agency.

CMS will continue to reimburse states for:

+ school-based direct Medicaid services in their approved state plans;
+ transportation costs related to school-aged children from school or home to a non-school-based direct medical service provider that bills under the Medicaid program, and from the non-school-based provider to school or home;
+ transportation costs related to children who are not yet school age and are being transported from home to another location, including a school, and back to receive direct medical services, as long as the visit does not include an educational component or any activity unrelated to the covered direct medical service;
+ administrative overhead costs that are integral to, or an extension of, a direct medical service and, as such, are claimed as medical assistance; and
+ school-based administrative activities, such as Medicaid outreach and eligibility intake, that are conducted by employees of the state or local Medicaid agency.

Government Provides Oversight

CMS indicated in the final rule it had concerns that schools have been incorrectly documenting administrative activities, leading to abusive claims for federal matching funds. And improper billing by school districts for administrative costs and transportation services under the Medicaid program has been a longstanding concern of the HHS Office of Inspector General (OIG) and the Government Accountability Office (GAO). Both have identified these categories of expenses as being susceptible to fraud, waste, and abuse.

In 2000, GAO issued a report indicating excessive and undocumented claims, lack of safeguards at the state level, and inadequate monitoring by CMS of Medicaid reimbursements for school-based claims. This report led to intense oversight by OIG.

In September 2005, OIG found that none of 120 transportation claims made by a city’s department of education complied with federal and state requirements, and it disallowed $96,110,877 in federal Medicaid funding.

In January 2006 it found that “at least $2.4 million was unallowable for one school district in Kansas because the school had allocated costs to Medicaid for school employees who did not perform Medicaid administrative activities, expenditures for which the district did not provide support, and education-related expenditures.”

In September 2006, OIG recommended that Minnesota state return $9.7 million out of $13 million claimed for administrative costs because some school districts, among other things, had inappropriately included adults in their proportional Medicaid share ratios that were to represent children only.

And in December 2006, the agency recommended that Nevada return $5.8 million in federal funds out of $12.5 million claimed for administrative costs. Unallowable costs included expenditures for capital, debt service, activities already fully reimbursed by sources other than Medicaid, and costs that were not related to Medicaid school-based administration.

View the final rule at http://a257.g.akamaitech.net/7/257/2422/01jan20071800/edocket.access.gpo.gov/2007/pdf/07-6220.pdf.

States to Exclude More Providers

“If you don’t comply with conditions of participation, we shouldn’t be paying you for services because you are not an appropriate provider.”

Credentialed failures also could lead to exclusion, Sheehan says. Hospitals and other institutions are expected to properly credential physicians. They must have current medical licenses and be credentialed through the medical staff peer review process, which is supposed to ensure that the physician is qualified to perform the services he or she is performing. Exclusion is one tool that can be applied “for failure to have systems and processes...
In place to detect and address poorly performing doctors,” Sheehan says.

In fact, New York is using increasingly sophisticated data analysis to identify providers who should be kept out of Medicaid. “Poor quality and excessive services and money improperly spent tend to occur in clusters,” Sheehan said.

“We want to use data to tell which organizations shouldn’t be in the program. The bottom 10% who can’t meet their obligations” might lose their Medicaid provider status. “Part of it is fraud, part of it is poor management,” he says, but the poor performers make themselves known in terms of both billing errors and poor quality of care.

State Also Offers Providers Guidance

But New York Medicaid also is offering the industry guidance on compliance. First, the state legislature mandated compliance programs for Medicaid participation, and a regulation implementing that mandate should be released by late February, Sheehan says.

A month or two later, the Medicaid Inspector General’s office is releasing its first in a series of compliance-program guidance documents. First up is guidance for hospitals. It will address all the usual risk areas, such as billing and coding, but also tackle quality, governance and business processes, he says.

In Medicaid billing audits, DRG coding will always be a top target because “there is more money paid based on DRG coding than any other kind of coding,” Sheehan says. Also, DRG coding — and turning those codes into bills — involves multiple people, opening the door to more chances for error.

And in New York, when Medicaid identifies DRG coding errors, CMS piggybacks on the data to flag DRG coding errors affecting Medicare. Advanced data-mining tools are increasingly turning that into standard operating procedure.

The same logic applies to minimum data set (MDS) coding for nursing homes. There is a lot of money being spent, the codes are fairly complex, and a lot of hands are involved in the coding and billing, he says.

New York has also recovered a lot of overpayments through matching projects, Sheehan says. Examples include hospitals billing patients as inpatients at the same time they are billed as outpatients; hospitals billing for ambulance transports for a date of service when the patient is hospitalized; patients billed to Medicaid while they are in prison or after they died; patients with multiple ID numbers; and physicians who are out of the country at the time the prescription is written. “We used to just get the money back,” he says, but now enforcement officials use these abuses as a roadmap to organizations that are more likely to have systemic problems.

Contact Sheeder at (214) 969-2900. ❖

NEWS BRIEFS

♦ The five subpoenas issued to WellCare Health Plans, Inc. by the Assistant U.S. Attorney in Tampa, Fla., “support our view that the investigation against WellCare is targeted in nature, and is not indicative of widespread fraud,” said Oppenheimer & Co. securities analyst Carl McDonald in a recent briefing paper. In November, McDonald states that the WellCare search warrant “appears to be fairly specific in nature and focused primarily on WellCare’s Medicaid business in Florida, particularly its behavioral health operation” (MCN 12/07, p. 6). If this is the case, then WellCare will ultimately settle with the government and pay a fine, but will likely remain in business, the analyst asserted. However, McDonald added that given the reams of documents taken by the FBI during the raid and the vast amount of information requested through subpoenas, the investigation will be drawn out and is likely still months from any real resolution. The company issued a statement Jan. 15, saying it believes that the investigations are “principally focused on the relationships of the company’s Florida health plans with the company’s behavioral health subsidiary, Harmony Behavioral Health, including the calculation by the Florida plans of a behavioral health refund to the Florida Medicaid agency and on the inter-company relationships between the company’s various health plans and other wholly-owned subsidiaries.” However, it says it has not been advised of the full scope of the investigations, and it “does not know whether the investigations may expand to other areas or the extent to which such investigations might lead to fines, penalties, operating restrictions or impacts on the company’s historical financial statements.” The company says it is also responding to subpoenas issued by Connecticut’s attorney general’s office regarding transactions between the company and its affiliated companies and their potential impact on the costs.
NEWS BRIEFS (continued)

of Connecticut’s Medicaid program. However, in the wake of the investigation, CEO and President Todd Farha, CFO Paul Behrens, and General Counsel Thaddeus Bereday have resigned from their positions with the company. Contact McDonald at carl.mcdonald@opco.com and WellCare spokesperson John Aberg at john.berg@wellcare.com.

♦ CMS issued a proposed rule Jan. 18 that would allow Medicaid beneficiaries to hire their own personal care assistants rather than use the services of home health agencies (73 Fed. Reg. 3546). The proposed rule would implement Section 6078 of the Deficit Reduction Act allowing states to choose to provide care to Medicaid beneficiaries in ways that previously would have required a waiver. Under the rule, states can administer self-directed personal assistance services, allowing Medicaid beneficiaries to receive a cash allowance to hire their own personal care assistants and purchase items such as wheelchair ramps. According to CMS, self-directed care allows Medicaid beneficiaries needing help with the activities of daily living to select, direct and manage their needed services under an individualized plan and budget. If a state does elect to adopt the self-directed personal assistance services option, beneficiaries could hire and train their own caregiver to assist with daily activities but not to direct medical care. A state must have an existing personal care service benefit or be operating a home- or community-based service waiver program before allowing this new option. CMS is accepting comments on the proposed rule through Feb. 19. View the rule at http://a257.g.akamaitech.net/7/257/2422/01jan20081800/edocket.access.gpo.gov/2008/pdf/08-115.pdf.

♦ South Carolina’s law providing administrative sanctions against Medicaid durable medical equipment (DME) suppliers fails to meet federal standards, said the HHS Office of Inspector General (OIG). During a review of the South Carolina Department of Health and Human Services’ reimbursements to DME suppliers, OIG found that the department did not take action against eight DME suppliers that violated federal standards and had their Medicaid supplier numbers revoked by the National Supplier Clearinghouse. The state’s law allows for administrative sanctions, including suspension or termination of a provider that fails to meet state or federal standards, said OIG. But the agency found that the state did not check the Medicare status of potential DME suppliers during the initial enrollment process. Thus, the state paid more than $2 million to some DME suppliers whose supplier numbers had been revoked. OIG recommended that the state revise the DME enrollment and renewal process to include verifying the validity of an applicant’s DME supplier number and consider suspending or terminating Medicaid DME suppliers who have had their supplier numbers revoked. The state expressed concerns regarding the administrative burden of having to check the status of DME suppliers. But OIG asserted that since the state enrolls approximately 14 new suppliers each month, it would be feasible for it to contact the clearinghouse to obtain the current status of the supplier numbers listed on those applications. Go to www.oig.hhs.gov/oas/reports/region4/40504010.htm.

♦ OIG has issued follow-up audits of the drug rebate programs in Kansas and the District of Columbia, finding that Kansas has complied with all of OIG’s recommendations from its prior audit and the District of Columbia had implemented some of the agency’s recommendations from its prior audit. OIG’s objectives in its audit of Kansas’s drug-rebate program were to determine whether the state had implemented OIG’s recommendations related to recording accounts receivable, reconciliation of Form CMS-64.9R and the general ledger, interest accrual, interest reporting, and invoice verification. Finding that Kansas had complied with both of these recommendations, OIG offers no further recommendations. With regard to the District of Columbia, OIG found that it had complied with its recommendations to accurately report outstanding rebates receivable and rebates collected and include rebates invoiced and adjustments on the Form CMS-64.9R, and include on the endorsement stamp the District’s name or the District’s bank-account number to ensure greater security of drug rebate checks. But OIG found that the District did not collect rebates on single-source drugs administered by physicians or establish controls over and accountability for their collection. Therefore, OIG is reiterating its recommendation that the District of Columbia implement a procedure to collect and submit utilization for single-source drugs administered by physicians so that it may obtain rebates for the drugs and collect rebates for single-source drugs, retroactive to Jan. 1, 2006, when it implements its single-source drug rebate program. Visit www.oig.hhs.gov.
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