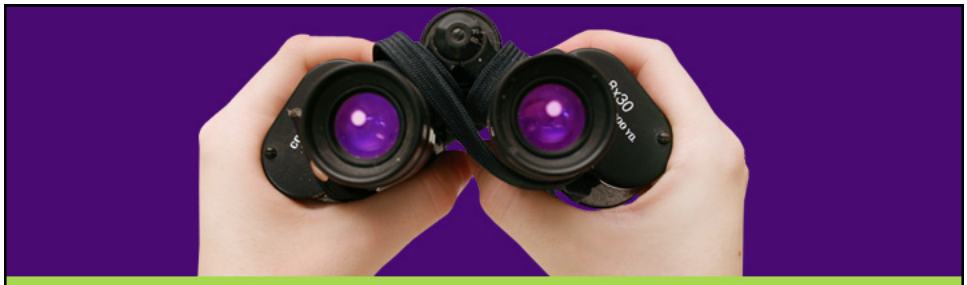

The HEAT Is On: Prepare Now for Enhanced Government Enforcement Efforts

Presenters:
Judy Waltz
Cheryl Wagonhurst

Friday, January 8, 2010

FOLEY
FOLEY & LARDNER LLP

9:30 a.m – 10:30 a.m. Pacific
10:30 a.m – 11:30 a.m. Mountain
11:30 a.m – 12:30 p.m. Central
12:30 p.m – 1:30 p.m. Eastern

Today's Presenters

Judy Waltz
San Francisco

Cheryl Wagonhurst
Los Angeles

Housekeeping

- We will take questions throughout the program via the Q & A tab located on your menu bar at the top of your screen and live questions at the end of the program
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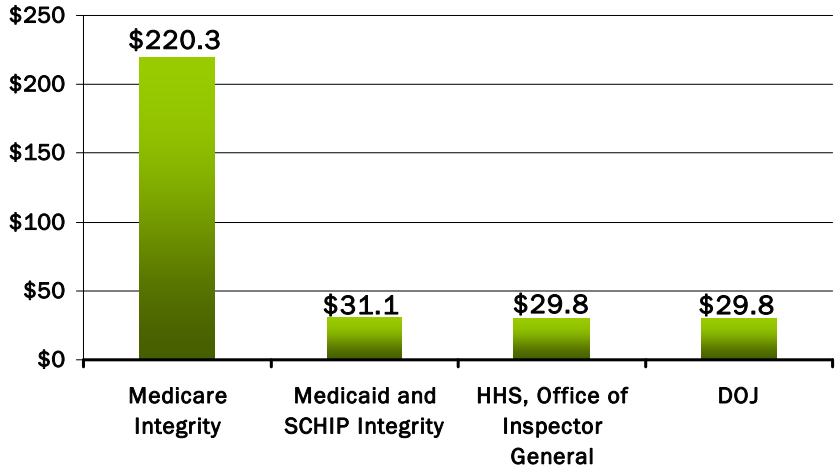
Roadmap for Today's Discussion

- Current Fraud and Abuse Initiatives
  - HEAT
  - Health Reform
  - 2009 Changes to the False Claims Act
  - Ramping up of the federal Medicaid Integrity Program and State Initiatives
  - RAC update
- Five Key Steps to Take Now!

FY 2010 Healthcare Fraud and Abuse Budget (in millions)



Source: White House, Office of Management and Budget. http://www.whitehouse.gov/omb/budget/fy2010/assets/hhs.pdf

Compliance/Enforcement is a Shifting Landscape

- My recent academic research suggests that companies should tackle the challenge of developing strategy head-on by describing the underlying logic, story lines, decisions and motives of all the players that are creating and capturing value in a business. Instead of drawing and analyzing a map or plotting numbers on a chart, executives should use words to create what I call a *playscript:* a narrative that sets out the cast of characters in a business, the way in which they are connected, the rules they observe, the plots and subplots in which they play a part, and how companies create and retain value as the business and the cast change.

Source: Jacobides, Michael G., "Strategy Tools for a Shifting Landscape," *Harvard Business Review* (January-February 2010).

Thompson Reuters White Paper (October 26, 2009)

- Estimates $700 billion wasted in US Healthcare system
  - Unnecessary care (40 %)
  - Fraud (19 %)
  - Administrative inefficiency (17 %)
  - Healthcare provider errors (12 %)
  - Preventable conditions (6 %)
  - Lack of healthcare coordination (6 %)

Source: Thompson Reuters Press Release: Waste in the U.S. Healthcare System Pegged at $700 Billion in Report from Thompson Reuters (October 26, 2009)

CMS Calculates its Own Error Rate (and Changes Methodology)

- On November 17th, 2009, CMS announced that for 2009 it had significantly changed the way it calculated Medicare fee-for-service (FFS) payment error rates
- According to the CMS, the change was aimed at providing CMS with more complete and accurate information so that it could better target improper payments as part of its ongoing efforts to weed out errors and fraud
- As a result of employing a more rigorous calculation methodology, CMS reported a 2009 FFS error rate of 7.8 percent (amounting to $24.1 billion) - over twice the 3.6 percent error rate reported in 2008

Source: CMS Press Release: HHS Employs New Tougher Standards In Calculation of Improper Medicare Payment Rates For 2009 Part of Administration-wide Strategy to Eliminate Errors and Prevent Waste and Fraud (Nov. 18, 2009)

Health Care Fraud Prevention and Enforcement Team

www.stopmedicarefraud.gov

HEAT Initiative Announced May 20, 2009

- Attorney General Eric Holder and Health and Human Services (HHS) Secretary Kathleen Sebelius announced the creation of a new interagency effort, the Health Care Fraud Prevention and Enforcement Action Team (HEAT)
- Reflects improving data sharing between CMS and law enforcement
- One goal: strengthening program integrity activities related to Medicare Parts C (Medicare Advantage plans) and D (prescription drug coverage) compliance and enforcement

HEAT – Geographic Focus

- As of December 15, 2009, HEAT strike forces are focused on 7 locations:
  - Tampa
  - Baton Rouge
  - Brooklyn
  - Detroit
  - Houston
  - Los Angeles (2007)
  - Miami (2007)
- Each strike force is led by a federal prosecutor from the respective U.S. Attorneys' Office or the Criminal Division's Fraud Section — Each team has an agent from the FBI and HHS-OIG

HEAT – Geographic Focus *(cont'd)*

- On December 11, 2009, the Department of Justice reported that since the inception of Strike Force operations in March 2007 – Miami (Phase One), Los Angeles (Phase Two), Detroit (Phase Three), and Houston (Phase Four) – the Strike Force has obtained indictments of more than 331 individuals and organizations that collectively have billed the Medicare program for more than $720 million

Source: HHS News Release December 15, 2009, "Medicare Fraud Strike Force Expands Operations into Brooklyn, N.Y.; Tampa, Fla.; and Baton Rouge, La; Continuing Strike Force Operations Lead to Indictment of 30 Individuals Charged in Miami, Detroit and Brooklyn with more than $61 Million in Fraudulent Billing to Medicare,: available at www.dhhs.gov/news/press/2009pres/12/20091215a; http://www.justice.gov/opa/pr/2009/December/09-crm-1332.html

HEAT – Focus on Datamining

- "We are actively analyzing Medicare data in unprecedented coordination between our two agencies [DOJ and HHS], and in as real-time as possible, to identify fraud "hot spots" and expand strike force operations to those areas where there is the most need."
  - Statement of Assistant Attorney General Tony West before the Senate Judiciary Committee Entitled "Effective Strategies for Preventing Health Care Fraud" (Wednesday, October 28, 2009)

HEAT – Focus on Datamining *(cont'd)*

- "CMS is building an Integrated Data Repository (IDR) that will, when completed, contain a wealth of data across several programs. Although the system is still under development, the prospect of such a comprehensive data warehouse holds considerable promise for detecting and preventing fraud and abuse."
  - Testimony of Daniel Levinson before the House Committee on Energy and Commerce, Subcommittee on Health (June 25, 2009)

HEAT – December 2009 Report

- California - December 20, 2009 - Audiologist Sentenced to Six Months in Prison for Medicare Fraud - Read More
- Texas - December 17, 2009 - Houston Physician Pleads Guilty to and Sentenced for Operating an Illegal Pill Mill - Read More
- Michigan - December 16, 2009 - Owner of Health Care Agency Sentenced to 18 Months Prison in Medicare Kickback Scheme - Read More
- South Carolina- December 15, 2009 - Lexington Doctor Sentenced in Fraud Case, to Perform Community Service - Read More
- Minnesota- December 15, 2009 - Plymouth man Pleads Guilty to Defrauding Medicaid out of $74,000 - Read More
- Georgia- December 14, 2009 - Miami Man Sentenced to More Than a Decade in Federal Prison for Million Dollar Medicaid Fraud Read More
- Pennsylvania- December 11, 2009 - Durable Medical Equipment Company, Six Others Charged in Medicare Fraud And Kickback Scheme - Read More

Source: www.Stopmedicarefraud.gov/heatsuccess/index

HEAT – December 2009 Report *(cont'd)*

- Illinois - December 7, 2009 - Corporation Pleads Guilty to Various Fraud Schemes - Read More
- Michigan - December 11, 2009 - SPECIAL RELEASE - Physical Therapist, Money Launderer and Patient Recruiter Plead Guilty in Connection With Multiple Detroit Health Care Fraud Schemes - Read More
- Michigan - December 8, 2009 - Meijer Resolves Voluntary Disclosure of Past Employment of Excluded Pharmacists - Read More
- New Hampshire - December 7, 2009 - Former New Hampshire Registered Nurse Pleads Guilty for Tampering with Dilaudid and Demerol Syringes at Southern New Hampshire Medical Center - Read More
- North Carolina - December 11, 2009 - Aulander Woman Pleads Guilty to $650,000 Health Care Fraud - Read More
- Texas - December 6, 2009 - Durable Medical Equipment (Dme) Business Owner In Dallas Pleads Guilty To Aggravated ID Theft In Medicare Fraud Scheme - Read More

Source: www.Stopmedicarefraud.gov/heatsuccess/index

HEAT – December 2009 Report
(cont'd)

- Florida - December 3, 2009 - Owner of Home Health Care Provider and Accomplice Arrested in Scheme to Bribe Government Contractor - Read More
- Idaho - December 3, 2009 - Two Convicted for Health Care Fraud - Read More
- Iowa - December 2, 2009 - Sioux City Hospital to Pay $400,000 to Resolve False Claims Allegations - Read More
- District of Columbia - December 1, 2009 - Maryland Man Admits Fraud on Hospital - Read More
- Florida - December 1, 2009 - Miami Man Arrested for Obstructing a Health Care Fraud Investigation - Read More
- Michigan - December 1, 2009 - Judge Fines Chiropractor $125,000 for Falsifying Records - Read More

Source: www.Stopmedicarefraud.gov/heatsuccess/index

DOJ's Elder Justice and Nursing Home Initiative

- "[T]he Civil Division houses the Elder Justice and Nursing Home Initiative to coordinate and support law enforcement efforts to combat elder abuse, neglect and financial exploitation of this population. . . . Each year Medicare and Medicaid spend over $120 billion on long-term care services, including nursing homes. At the same time, research shows that 11 percent of our seniors report experiencing at least one form of abuse, neglect, or exploitation. The Department created the Elder Justice and Nursing Home Initiative to focus on preventing this abuse and protecting our seniors. The Initiative has invested significant dollars to study elder abuse risk factors so that we can develop systems to prevent abuse before it occurs.

Source: Statement of Assistant Attorney General Tony West Before the Senate Judiciary Committee Entitled "Effective Strategies for Preventing Health Care Fraud" (Wednesday, October 28, 2009), available at www.justice.gov/dag/testimony/2009/dag-testimony-091028

DOJ's Elder Justice and Nursing Home Initiative *(cont'd)*

- But when abuse and/or neglect does occur, the Elder Initiative coordinates the Department's litigation against long-term care providers, including nursing homes that fail to provide the quality of care to which our Medicare and Medicaid beneficiaries are entitled. Over the years, the Department, through the Elder Initiative, has worked with the HHS Inspector General and his office to recover fraudulently received money from long-term care facilities and to force these nursing homes to improve the care they provide to their residents.

Source: Statement of Assistant Attorney General Tony West Before the Senate Judiciary Committee Entitled "Effective Strategies for Preventing Health Care Fraud" (Wednesday, October 28, 2009), available at www.justice.gov/dag/testimony/2009/dag-testimony-091028

Healthcare Reform: Enhanced Focus on Reducing Fraud, Waste and Abuse

Healthcare Reform – Funded by Reducing Waste and Abuse?

- As of this date, final provisions (and passage) are yet to come - but there are important themes and significant similarities in the House and Senate bills
  - "[W]e've estimated that most of this [healthcare reform] plan can be paid for by finding savings within the existing health care system, a system that is currently full of waste and abuse." Remarks by President Obama to a Joint Session of Congress, Sept. 9, 2009 (available at www.whitehouse.gov).
  - Article: John K. Inglehart, "Finding Money for Health Care Reform -- Rooting Out Waste, Fraud and Abuse," New England Journal of Medicine, 361 NEJM 229 (2009)

OIG's Five-Principle Strategy to Combat Health Care Fraud, Waste, and Abuse

1. Enrollment - Scrutinize individuals and entities that want to participate as providers and suppliers prior to their enrollment in health care programs
2. Payment - Establish payment methodologies that are reasonable and responsive to changes in the marketplace
3. Compliance - Assist health care providers and suppliers in adopting practices that promote compliance with program requirements, including quality and safety standards

OIG's Five-Principle Strategy...*(cont'd)*

4. Oversight - Vigilantly monitor programs for evidence of fraud, waste, and abuse
5. Response - Respond swiftly to detected fraud, impose sufficient punishment to deter others, and promptly remedy program vulnerabilities

Source: Testimony of Inspector General Dan Levinson before the House Committee on Energy and Commerce, Subcommittee on Health (June 25, 2009)

Healthcare Reform –
Significant Fraud and Abuse Provisions of House and Senate Bills

- Mandatory compliance programs under Medicare and Medicaid
- Increased funding for fraud and abuse activities (House: $100m/year, Senate: $10m/year)
- Senate bill expands RACs to Medicaid and Medicare Parts C and D
- Senate bill would eliminate the *Hanlester* defense, state that actual knowledge of or specific intent to violate the Anti-Kickback Statute is not required to violate the Anti-Kickback Statute
- Overpayments to be returned within 60 days (Senate allows for delay until corresponding cost report is due)

Healthcare Reform –
Significant Fraud and Abuse Provisions of House and Senate Bills *(cont'd)*

- Elimination of Stark law exception for new physician-owned hospitals and new rural hospitals. Effective dates differ. Hospitals currently utilizing the exceptions are subject to additional requirements.
- "Sunshine Act" reporting provisions for payments to covered recipients (definitions differ) by drug and device manufacturers (and distributors, by House bill). House bill is much broader. Some preemption of state laws.

The Federal False Claims Act – Changes and Impact

False Claims Act

- The False Claim Act (31 U.S.C. § 3729) imposes liability for persons who
  - Present or cause to be presented
  - A false or fraudulent claim for payment to the U.S. government
  - With knowledge the claim is false
    - Deliberate ignorance or reckless disregard will satisfy the knowledge element
- Violations may lead to triple damages

FCA Settlement Figures (per DOJ)

- Total FCA settlements and judgments from 1986 to 2008: $21.6 billion
  - Whistleblower share over that period: $2.2 billion
- Total *healthcare* FCA settlement and judgments from 1986 to 2008: $14.3 billion
  - Whistleblower share over that period: $1.6 billion

(Source: Fraud Statistics – Overview, October 1, 1986 to September 30, 2008, Civil Division, U.S. Department of Justice)

Enforcement of Quality of Care Through the False Claims Act

- The government uses a variety of legal theories under the FCA to attack quality failures, but all follow the same principle: **the government will not pay for medically unnecessary or substandard care**
- Physicians, executives, and board members face *real risks* for poor quality of care

Enforcement of Quality of Care Through the False Claims Act *(cont'd)*

- OIG will examine quality of care issues to detect and prevent fraud and abuse perpetrated against beneficiaries and the Medicare and Medicaid programs
- Medically unnecessary services
- Services either not rendered, not rendered as prescribed, or for substandard care that is so deficient that it constitutes a "failure of care"
- Serious medical errors – never events
- Reliability of hospital – reported quality measure data
- Medicaid statistical information system data reporting

Enforcement of Quality of Care Through the False Claims Act *(cont'd)*

- "OIG will continue to examine quality of care issues for beneficiaries residing in nursing facilities and other care settings . . . . We will expand our focus on these issues to additional institutions and community-based settings." (OIG 2010 Work Plan)
- Laura Ellis, Sr. Counsel, Administrative and Civil Remedies Branch, Office of Counsel to the OIG – 10/12/09
- James Sheehan, Medicaid Inspector General, NYS OMIG – 10/11/09

OIG 2010 Work Plan

- Significant focus on quality of care and reporting
- Commitment to investigate health care fraud related to quality of care, *i.e.* billing for unnecessary services or for substandard care ("failure of care")
- See pages 67 & 68 of 2010 Work Plan

Use of Data Mining in Enforcement Actions

Data Mining

- Defined:
- Data mining is a ***technology*** that facilitates the ability to ***sort*** through masses of information through database exploration, extract specific information in accordance with defined criteria, and then ***identify patterns of interest*** to its user.
- Goals
  - Correct inappropriate behavior
  - Identify overpayments
  - Deny payment

Data Mining

- *"We are reviewing assorted sources of quality information on your facility to see what it says and if it is consistent. You should be doing the same."*

  James G. Sheehan

  Medicaid Inspector General, New York

  February 6, 2007

Quality of Care Enforcement Actions & Settlements

- Tenet Healthcare Corporation
  - Multiple Settlements with DOJ & OIG
  - Forced Divestment of Redding Hospital
  - 5-year Corporate Integrity Agreement
    - Board Committee Reports to OIG on quality
    - IRO review of clinical quality management
    - Quality-of-Care Failure Reporting Requirement to OIG

Recent Quality of Care Enforcement Actions & Settlements

- Quest Diagnostics Incorporated
  - $302 million global settlement
  - 5-year Corporate Integrity Agreement
    - Compliance Expert to Board
    - IRO reviewing compliance with FDA Quality System Regulation

Recent Quality of Care Enforcement Actions & Settlements *(cont'd)*

- Emmanuel Bernabe
  - Owner & President, Nursing Home Corporation
  - Permanent Exclusion from participation in Federal Health Care Programs
- Grant Park Nursing Home
  - $2 million settlement
  - 5-year Corporate Integrity Agreement with Quality Monitor

Whistleblower Recoveries

- FCA relators are given a significant financial incentive to "blow the whistle"
- With some exceptions, *if the government intervenes*, the relator is entitled to not less than 15% and not more than 25% of the recovery, plus reasonable expenses and reasonable attorneys' fees and costs
- *If the government does not intervene*, the court will decide what is reasonable. This can range from 25% to 30%, plus reasonable expenses, as well as reasonable attorneys' fees and costs, which are paid by the defendant

FCA Basics: Who Can Be a Whistleblower

- Private citizens, called "relators" or whistleblowers, may bring FCA actions in the name of the government
- The relator may be barred from recovery if the underlying matter has been publicly disclosed and the claim is not brought by an original source
- The FCA protects whistleblowers from retaliatory action

2009 Amendments to the False Claims Act

- Fraud Enforcement and Recovery Act of 2009 (FERA)
- Signed into law on May 20, 2009
- Provides hundreds of millions in new funding for federal law enforcement, SEC and DOJ
- Amends the FCA in several significant ways

2009 Amendments to FCA

- Revisions to "Presentment" clause: The revised definition of "claim" clarifies that the request for payment may be made to: (1) An officer, employee or agent of the United States; OR (2) A contractor, grantee or other recipient,
- "To get" - overruled case law by deleting the "to get" [a claim paid] language and incorporating the more expansive definition of "claim"
- "Reverse" false claims - FCA liability for any person who "… knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay or transmit money or property to the Government" [i.e., retention of an overpayment]

2009 Amendments to FCA *(cont'd)*

- Civil Investigative Demands – easier to get; allows shared information with relators (whistleblowers)
- Increased Whistleblower Protection - Whistleblower protection extended to contractors and agents (in addition to employees); protection from being "discharged, demoted, suspended, threatened, harassed, or in any manner discriminated against…"

Pending Qui Tams

- According to the figures released to Grassley from the Justice Department, there are:
  - 985 qui tam healthcare fraud cases pending a decision to intervene
    - 200 qui tam cases have to do with pricing and marketing pharmaceuticals
  - 130 pending qui tam cases the Justice Department has joined (not just healthcare)
  - 490 cases that the Justice Department has declined to intervene (not just healthcare)

Source: Sen. Grassley Press Release (October 7, 2009)

Focus on Medicaid Enforcement

(Federal and State)

Medicaid Integrity Program

- Deficit Reduction Act of 2005 (DRA) created new federal Medicaid Integrity Program (MIP)
- DRA dramatically increased Resources of CMS & HHS-OIG to Fight Medicaid Fraud
- Funding - $560M over 5 years
  - $255m For Medicaid Integrity Program
  - $180m for National Medi-Medi Expansion
  - $125m for OIG Medicaid Fraud
- Staffing – 100 FTEs for CMS
- As of Fall 2009, audit activity now underway in at least 25 states

Medicaid Integrity Program *(cont'd)*

- DRA also required policies and procedures which advised employees of false claims acts and whistleblower protections
- MIG (Medicaid Integrity Group) is developing algorithms to streamline audits
  - Algorithms allow for "data mining" by using "structured queries" to elicit specific information (e.g., potential billing errors for one-day hospital stays)
    - This allows investigators to quickly identify potential billing errors
    - Allows MIP to check all Medicaid claims in a state for a particular error in 30 to 60 minutes (i.e., can check all claims in the U.S. for the error in 25 to 50 hours)

Medicaid Managed Care Enforcement

- Amerigroup Corp. (2008)
  - After jury verdict in N.D.IL., settled claims of Medicaid fraud for $225 million
  - Amerigroup required by law to enroll all eligible beneficiaries, but avoided enrolling unhealthy patients and pregnant women
  - Case driven by Ill. Attorney General Lisa Madigan
- HealthFirst (2008)
  - Reached $35 million settlement with NY over alleged violations of its Medicaid managed care contract and false marketing plans filed with state and city officials

New York Office of Medicaid Inspector General – 2008 Results

- OMIG succeeded in saving the state **$1.66 billion** through cost-savings activities (including nearly **$134 million** in recipient restrictions) during 2008.
- During federal fiscal year 2008-09 (October 1, 2007-September 30, 2008), the OMIG met and exceeded federal identification and recovery requirements under the Federal-State Healthcare Reform Partnership (F-SHRP). The goal was $215 million, and, in collaboration with OMIG's state agency partners particularly the New York State Office of the Attorney General, New York reached **$551 million**.
- OMIG began 3,281 investigations in 2008; and completed 2,366.

New York Office of Medicaid Inspector General – 2008 Results *(cont'd)*

- In 2008, 921 investigations began as the result of information the OMIG received from the fraud hotline.
- OMIG excluded 660 providers from participating in the Medicaid program in 2008, and terminated 39.
- OMIG referred 88 cases to the New York State Attorney General for potential prosecution as criminal cases; 72 were providers, while 16 were recipient cases.
- OMIG referred 531 cases to other state agencies; the vast majority of those (496) were referred to local social services districts for investigation at the local level.
- OMIG auditors initiated 2,532 audits and completed 1,738.

Source: 2008 Annual Report, available at www.omig.state.ny.us

States with Medicaid Inspectors General

Florida	Agency for Health Care Administration, Inspector General
Georgia	Department of Community Health, Office of Inspector General
Illinois	Department of Community Health, Office of Inspector General
Kansas	Health Policy Authority, Office of Inspector General
Kentucky	Cabinet for Health and Family Services, Office of Inspector General
New Jersey	Office of Inspector General, Medicaid Inspector General (Medicaid IG information not yet on OIG website)
New Mexico	Human Services Department, Office of Inspector General
New York	Office of the Medicaid Inspector General
Texas	Health and Human Services Commission, Office of Inspector General

Recovery Audit Contractors

Expansion Update

CMS RAC Review Phase-in Strategy as of 06/24/09

Earliest possible dates for reviews in yellow/green states

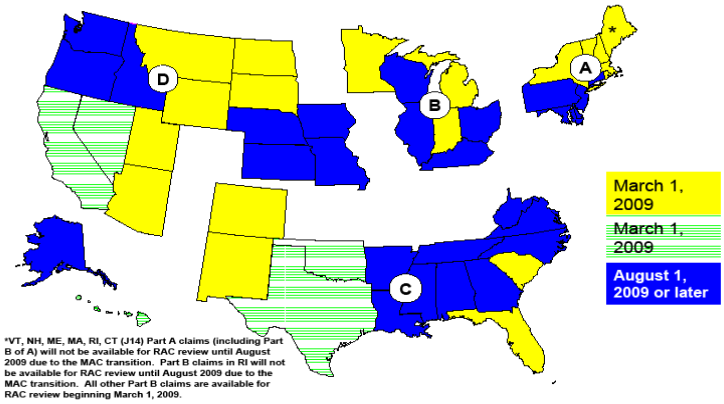
- Automated Review-Black & White Issues (June 2009)
- DRG Validation-complex review (Aug/Sept 2009)
- Complex Review for coding errors (Aug/Sept 2009)
- DME Medical Necessity Reviews – complex review (Fiscal year 2010)
- Medical Necessity Reviews-complex review (calendar year 2010)

Earliest possible dates for reviews in blue states

- Automated Review-Black & White Issues (August 2009)
- DRG Validation-complex review (Oct/Nov 2009)
- Complex Review for coding errors (Oct/Nov 2009)
- DME Medical Necessity Reviews – complex review (Fiscal year 2010)
- Medical Necessity Reviews-complex review (calendar year 2010)

Source: Recovery Audit Contractors (RACs) and Medicare
Connie Leonard, Director, Division of Recovery Audit Operations
Cmdr Marie Casey, Deputy Director, Division of Recovery Audit Operations Centers for Medicare & Medicaid Services, available on CMS website, www.cms.gov

RAC Phase In Schedule



Source: CMS website, January 3, 2010

Five Key Steps That Health Care Entities Can Take Now in Order to Reduce Risks

Step One – Get Your Board and Management Team on Board

- Critical for health care providers to involve board of directors in order to:
  - Set tone at the top
  - Provide guidance and leadership
  - Keep management in check
  - Keep physician leadership in check

Step One – Get Your Board and Management Team on Board *(cont'd)*

- Resources for Boards
  - "Corporate Responsibility and Corporate Compliance: A Resource for Health Care Boards of Directors" (OIG/AHLA)
  - "Driving For Quality in Long-Term Care: A Board of Directors Dashboard" Government-Industry Roundtable (OIG/HCCA)
  - "Driving for Quality in Acute Care: A Board of Directors Dashboard" Government-Industry Roundtable (OIG/HCCA)

Step One – Get Your Board and Management Team on Board *(cont'd)*

- Better nail it down with management first
- Presenting "live" issues to the board
- Don't ignore operational impact – pay for performance, etc.

Step Two – Assess Your Compliance Program and Develop an Action Plan

- Is your current program stale?
- Is your current program structured in a way to address today's risks?
- Look at your resources, dollars spent on program commitment, tone at the top, liaison support
- Don't just focus on seven elements!!!
- Develop a Plan – short term and long term

Step Three – Implement Action Plan by Engaging in Proactive Information Dissemination and Training Efforts

- Management and employees need to understand environment and impact
- Consider revisions to practical policies and procedures
- Consider new ways of disseminating information in your organization
- Training must zero in on how to spot an issue which could trigger enforcement scrutiny

Step Four – Implement Action Plan by Engaging in Proactive Auditing and Monitoring Efforts

- Mine your own data before the government does it for you!!! This is an obvious point – essential!
- Understand where your state Medicaid office is in its enforcement efforts and use of data
- Use of Hospital Compare

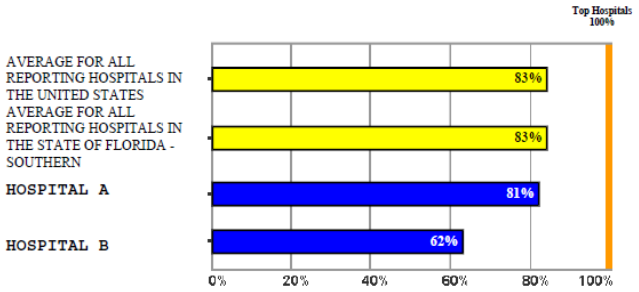
Hospital Compare

HHS - Hospital Compare - Process of Care Measure Graphs

Graph 1 of 4

Percent of Heart Failure Patients Given ACE Inhibitor or ARB for Left Ventricular Systolic Dysfunction (LVSD)

The rates displayed in this graph are from data reported for discharges April 2006 through March 2007.



Top Hospitals represents the top 10% of hospitals nationwide. Top hospitals achieved a 100% rate or better.

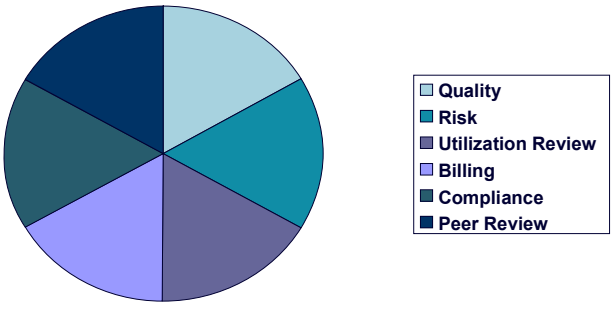
Step Five – Integrate Quality of Care into Your Compliance Program

- No time for continued turf wars
- Quality of Care must be recognized as a compliance risk
- Break down the silos

Old Structures – SILO Approach

PEER REVIEW | QUALITY | RISK | UTILIZATION REVIEW | COMPLIANCE | BILLING

New Structure Needed



Wrap Up Summation

- In today's enforcement environment, everyone is the low hanging fruit
- Assess where you are in addressing these new risks
- Get your organization's support and develop and implement a plan

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