The Week in Healthcare

QUALITY » *Joe Carlson*

Tables being turned on auditors

HHS' inspector general wants to investigate audit contractors

The auditor has become the audit target.

Along with reviewing things like electronic health records and patient-discharge practices, HHS' inspector general's office announced plans to investigate the private companies that the CMS has hired under contract to audit hospitals and doctors' offices.

The annual workplan of the inspector general revealed upcoming reviews related to Medicare administrative contractors, which process and analyze claims from healthcare providers; recovery audit contractors, which audit for waste and abuse of the system; and zone program integrity contractors, which look for fraud.

"I don't think the contractors do a particularly effective job," said Lewis Morris, who entered private practice at Adelman, Sheff & Smith in Annapolis, Md., this year after retiring from his longtime role as chief counsel to HHS' inspector general in April. "In part it is because of inadequate oversight by CMS."

The CMS did not respond to requests for comment. The workplan also includes a review of how the CMS monitors its contractors, in Medicare and in other programs, in light of recent findings by the Government Accountability Office that the CMS harbors what the inspector general called "pervasive deficiencies" in how it manages a fleet of contractors that earned $4 billion in 2009.

Stuart Wright, deputy inspector general for evaluations and inspections in the inspector general's office, said in a taped video recently posted online that the CMS' management of contractors has long been a focus of scrutiny. Those reviews have turned up concerns about low levels of new-case development, low numbers of referrals to law enforcement and inconsistent definitions of fraud terms.

"Over the years, we have found a number of issues associated with these entities," Wright said in the video. "We plan a number of studies to continue to look at the actual operations to

MEDICARE » *Joe Carlson*

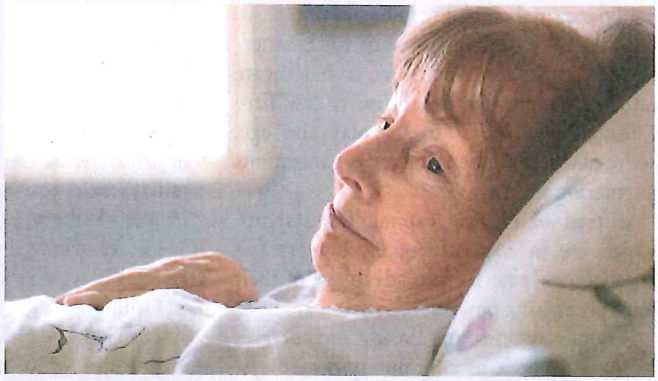
Shedding the myth

HHS to clarify language on eligibility

After years of uncertainty, patient advocates unveiled a proposed class-action settlement that they say would dispel a common Medicare "myth" that has limited services for people with chronic diseases.

The tentative settlement between HHS and a coalition of Medicare beneficiaries and interest groups for chronic-disease patients would jettison what has come to be known as the "improvement standard"—a concept that has been used to deny skilled-nursing and physical-therapy services to Medicare beneficiaries with conditions such as Alzheimer's, multiple sclerosis and Parkinson's disease, whose health would not "improve" from the care.

HHS has agreed to clarify Medicare manuals to say that a need for services, not the likelihood of future improvement, is the standard by which eligibility should be judged. Proponents of the change say the amended rule would provide more people with healthcare in the home, at skilled-nursing facilities and in outpatient-care settings.



JOSHUA BRIGHT/THE NEW YORK TIMES/REDUX

Rosalie Berkowitz, who was denied services under Medicare, may find it easier to qualify for coverage under planned policy changes.

No one knows how many Medicare patients will be affected, but advocates put the number in the tens of thousands. Many will be able to reapply for review of their eligibility under the new rules.

Although the settlement still requires a federal judge's final approval that is more than a year away, an attorney with one of the public-interest law firms that filed the case urged Medicare providers and payers to begin abiding by the settlement terms now since the changes only clarify existing rules.

determine whether these entities are operating in terms of what they're supposed to be doing for the government."

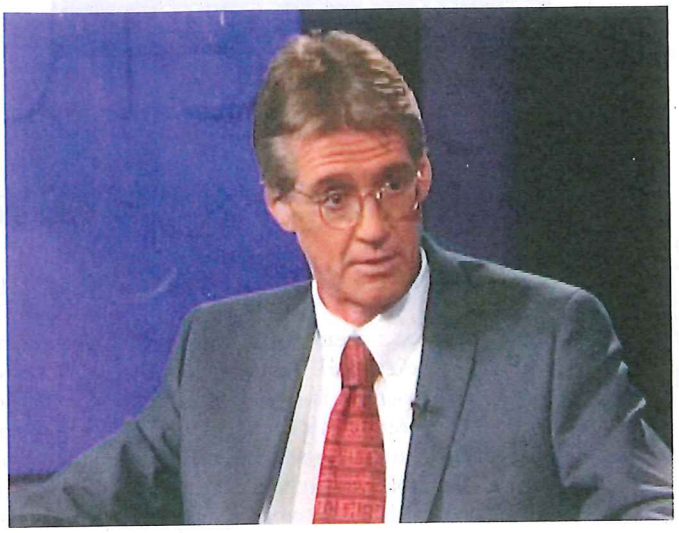
The American Hospital Association applauded the decision to audit the auditors, noting that hospitals often respond to redundant audit requests on the same claim. "These redundant audits drain time, funding and attention that could more effectively be focused on patient care," the trade group said in an Oct. 24 letter to the inspector general.

But rather than take any pleasure in watching auditors be investigated, hospital executives had better pay attention to their own operations, experts say, because there are plenty of investigations to go around—25, in fact, just on hospitals in the workplan.

Electronic health records continue to be a hot area of interest for HHS' inspector general's office.

The review, titled "Fraud Vulnerabilities Presented by Electronic Health Records," had been slated for release in 2012 and is marked "work in progress" in the 2013 workplan.

Meanwhile, executives at an untold number of hospitals hit an Oct. 26 deadline to fill out a survey from the inspector general's office asking detailed questions about use of the systems. The survey asks whether the hospitals allow clinicians to "cut and paste" information between records,



HHS' Stuart Wright, in a video posted online, said reviews of contractors have turned up several concerns.

and whether the systems are used to select billing codes, among other things.

Pamela McNutt, chief information officer at Dallas' Methodist Health System, which received one of the surveys, said recent focus on whether the record systems were increasing hospitals' revenue overlooked the larger goals of using the federally subsidized systems to improve quality tracking and documentation accuracy.

"So if we use tools that help us do better at that, now there are assertions that we are doing that only to increase our revenue?" she said. "That's kind of odd."

The 2013 workplan also includes at least nine reviews of precisely how hospitals admit, readmit and classify patients. Morris said investigators are interested to know whether hospitals are "gaming the system" with their admissions practices.

One review will examine whether they are admitting Medicare beneficiaries who should have been outpatients, and another will look at whether some discharged patients should have been recorded as less-costly "transfers" to other providers, according to the workplan. Investigators also want to look at quality-of-care concerns regarding transferred patients who have conditions recorded as "present on admission" at the second hospital but not at the first.

Matthew Fisher, an associate with Mirick O'Connell and chairman of the Boston law firm's health law group, said providers ought to be aware of the office's activities because auditors sometimes infer the existence of fraud "where it's not actually fraud."

"It's the overall environment now, where everything is being questioned," Fisher said. "It's a very tough environment for providers. And the initiatives announced in the workplan are consistent with what we've been hearing for a few years now, which is that they're going to be looking at everything." «

It's not clear how the increase in these Medicare services will affect federal spending.

"Under this proposed settlement, Medicare policy would be clarified so that claims from providers will be reimbursed consistently and appropriately," an HHS spokeswoman said in an e-mail. "Because this proposed settlement would clarify existing policy, we do not expect changes in cost relative to what has been projected."

Kathy Dodd, founder and CEO of home-care consulting firm Corridor Group, Overland Park, Kan., also noted that the cost changes are tough to predict because the services being rendered are often for health maintenance that could prevent expensive institutionalization and acute care in the long run.

"I do think in the end it will be a wash," she said. "You'll have cost transference, but I do think there will be savings. Because there is no way you can equate the low cost of an intervention in a home to what it costs to walk across the threshold of a hospital door. There is just no comparison."

In March 2011, Glenda Jimmo, 76, of Bristol, Vt., became the lead plaintiff in a federal class-action lawsuit against HHS to get the government to overturn the "improvement standard" that she said was being enforced by Medicare contractors, providers and administrative review officials.

Jimmo is a legally blind amputee with numerous chronic conditions, including diabetes with a circulatory disorder, transient cerebral ischemia, vascular disease and angina.

But her doctor-ordered skilled-nursing and home-care services were denied by a Medicare contractor and an administrative law judge because there was no evidence that the treatments were going to result in a change in her condition.

Jimmo argued that the official Medicare Benefit Policy Manual contains no "improvement standard" for nursing and therapy services.

"The improvement standard, what we call the myth, just pervades healthcare settings," said Judith Stein, founder and executive director of the Center for Medicare Advocacy, one of the law firms that filed the class-action case on behalf of Jimmo and a dozen other patients and chronic-disease interest groups.

HHS officials eventually agreed. They filed a settlement agreement in the U.S. District Court in Vermont on Oct. 16 in which they agreed to clarify existing policies to reflect the fact that future improvement should not be a basis for deciding whether to cover skilled nursing and physical therapy under Medicare.

The agency also agreed to send out letters to Medicare contractors and hold public meetings to advertise the point, and do follow-up monitoring to ensure the rules were being followed. Beneficiaries who received incorrect final determinations of coverage on or after Jan. 18, 2011, can apply for re-review of their cases once the settlement is finalized.

An attorney for the Center for Medicare Advocacy estimated that U.S. District Chief Judge Christina Reiss isn't likely to grant final approval of the settlement until January 2014. «