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Deadline for Implementing Identity Theft Prevention Programs Delayed

The Federal Trade Commission (FTC) recently delayed the approaching deadline for rules requiring many companies to implement identity theft programs. The original deadline was November 1, 2008, but the FTC has suspended enforcement of this rule until April 1, 2009. These programs should be designed to identify, detect, and respond to patterns, practices, or specific activities that could indicate identity theft, also known as “Red Flags”.

The Red Flag Rules apply to all “creditors” with “covered accounts,” which could include many health care providers. Under the FTC regulations, a creditor means “any person who regularly extends, renews, or continues credit; any person who regularly arranges for the extension, renewal, or continuation of credit; or any assignee of an original creditor who participates in the decision to extend, renew, or continue credit.” Credit is defined as “the right granted by a creditor to a debtor to defer payment of debt or to incur debts and defer its payment or to purchase property or services and defer payment therefor.” Health care providers fall under the definition of a creditor when they allow patients to defer some or all of the payment owed until some time after the services were rendered.

The rules are only applicable to those creditors subject to the administrative enforcement of the Fair Credit Reporting Act (FCRA) by the FTC. The FTC typically governs only for-profit entities, but because the FCRA does not restrict enforcement to for-profit corporations, the Red Flag Rules are likely to apply to non-profit providers as well. Additionally, the Red Flag Rules only apply to creditors with “covered accounts,” which are defined as accounts that are “primarily for personal, family or household purposes, that involves or is designed to permit multiple payments or transactions,” or any other account “for which there is a foreseeable risk to customers or to the safety and soundness of . . . the creditor from identity theft.” Under either or

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these definitions, patient accounts are likely to be considered “qualified accounts”.

Although, there are multiple tests seemingly limiting the applicability of the Red Flag rules, the bottom line is that they are written broadly enough to encompass most health care providers who do not collect payment in full at the time services are rendered, regardless of whether they are non-profit or for-profit entities.

Those falling under the purview of the rule are required to develop and implement a written Identify Theft Prevention Program (Program) that is designed to detect, prevent, and mitigate identity theft in connection with the opening of an account or existing account. More specifically, the Program must include reasonable policies and procedures to:

- Identify Red Flags and incorporate those Red Flags into the Program
- Detect Red Flags already incorporated in the program
- Respond appropriately to any Red Flags that are detected
- Ensure the Program is updated periodically to respond to risks to customers and to the safety and soundness of the creditor from identity theft

The deadlines have been extended to allow sufficient time for companies, like not-for-profit health care organizations, who are usually not subject to FTC regulation, to establish and implement these programs.

For more information or assistance in complying with the rules please contact Mark Colucci at mjc@kgrlaw.com or Linda Batten at lmb@kgrlaw.com.

Trends and Expectations in Health Care Litigation

In an October 2, 2008 article, the Kansas City Star reported that “litigation and enforcement actions against U.S. companies were down over the last year, but in-house corporate lawyers are gearing up for a surge in new cases and regulatory action contracts amid the nation's economic woes” The Star also reported on a portion of the findings contained in the Fifth Annual Litigation Trends Survey Findings, conducted and published by Fulbright & Jaworski, LLP, which found that one third of the 358 in-house counsels it polled anticipated an increase in litigation involving their companies and about a quarter expect an increase in regulatory proceedings. The survey revealed that almost 80% of U.S. companies reported involvement in at least one lawsuit in the past year and 27% reported being faced with more than 20 lawsuits.

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Such trends will likely find their way into the health care industry given current initiatives by the Centers for Medicare & Medicaid Services (CMS) and the HHS Office of the Inspector General (OIG) to recoup money attributed to fraud and abuse and overpayments.

The litigation survey indicated insurance companies were the leading target of litigation. Other significant areas of litigation include labor/employment and contract cases. As the economy continues to struggle, that trend will likely continue. For example, the Indianapolis Business Journal reported on October 18, 2008, that St. Francis Hospital system has declared WellPoint to be in breach of contract for failing to pay claims on a timely basis.

Health care companies should be aware of the current litigation trends. Although it may be difficult to predict or prevent becoming the target of litigation or regulatory actions, health care companies can evaluate current policies and procedures and their compliance programs to determine whether appropriate safeguards have been established and whether such policies are actually put into practice as written.

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OIG Approves Gainsharing Arrangement Involving Pay-For-Performance

On October 14, 2008, the HHS Office of the Inspector General (OIG) issued an opinion approving of a hospital's proposed arrangement to share its pay-for-performance compensation with a physician owned entity for its help in meeting certain quality targets. Under the hospital's current compensation arrangement with a private insurance company, the insurer pays the hospital bonus compensation based on a percentage of the base compensation paid to the hospital if the hospital meets certain standards of quality and efficiency ("Quality Targets"). Under the proposed arrangement, the physician group will require its members to take steps such as developing policies, conducting peer review, and auditing medical records to ensure that the Quality Targets are met. In return, the hospital will pay the physician group a percentage of its Quality Targets bonus compensation.

The OIG stated that the proposed arrangement could implicate the Civil Monetary Penalty (CMP), which prohibits payments to a physician as an inducement to reduce or limit items or services to

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Medicare or Medicaid beneficiaries under the physician's direct care. However, the OIG stated it would not seek sanctions in this instance because the arrangement included sufficient safeguards to prevent fraud and abuse. Those safeguards include:

- credible medical evidence that meeting the Quality Targets will improve patient care;
- the absence of an incentive for a physician to apply a specific standard in medically inappropriate circumstances;
- Quality Targets that are reasonably related to the practices and patients of the hospital;
- performance measures that are "clearly and separately" providing transparency; and
- the certification by the hospital that it would monitor the arrangement to protect against inappropriate reductions or limitations in patient care or services.

In addition, the OIG stated that the proposed arrangement could be a violation of the anti-kickback statute, which prohibits payments to physicians to induce or reward referrals. However, the OIG determined that the arrangement posed a low risk of violating the anti-kickback statute because:

- membership in the physician group is limited to physicians who have been on active medical staff of the hospital for at least a year, which will limit the likelihood that the arrangement will attract physicians specifically to share in the quality compensation;
- compensation will be paid to all members of the physician group and is not based on value or volume of referrals;
- the physician group will be paid only for meeting Quality Targets, not for increased referrals; and
- the private insurer will provide oversight to ensure that payments to physicians will be based on Quality Targets, not referrals.

Pay-for-performance is an increasingly prevalent form of reimbursement, but, as the OIG indicated, gainsharing arrangements with physicians involving pay-for-performance can implicate both the CMP and the anti-kickback statute. However, such arrangements may be acceptable if sufficient safeguards are in place to protect against fraud and abuse. Therefore, it is imperative that such arrangements are structured to prevent fraud and abuse.

For more information contact Linda Batten at lmb@kgrlaw.com or Mark Colucci at mjc@kgrlaw.com.

