STATLAW® New York

Volume XXIII Number I– January 15, 2015
Single Issue Price: $5.00

Late breaking news on medical-legal developments affecting physicians and health care professionals

Medicare Penalties Starting to Take a Toll on Hospitals: More than three dozen hospitals across the U.S. will be penalized more than 3% on most of their CMS reimbursements in 2015, the first year in which the agency's three (3) Medicare quality and safety incentive programs will be in effect. New this year is a 1% penalty on all Medicare revenue if a hospital falls into the bottom quartile in performance on hospital acquired conditions, or HACs, such as urinary catheter infections.

The escalating penalties are drawing fire from advocates for teaching hospitals and critical-access hospitals, which are disproportionately represented among the worst-performing hospitals. Critics argue that the CMS programs need to be refined to ensure they are not creating additional hardships and adverse comparisons. Some hospital leaders warn that the combined cuts across all Medicare penalty programs may have a cascading effect on services and may actually lead to reduced quality.

Unless Congress reverses the programs, an unlikely event, higher penalties are expected in coming years. The combined financial impact is expected to be sizeable. By 2017, the combined penalties for HAC 30-day readmissions and value-based purchasing will put as much as 5.5% of inpatient Medicare payments at risk.

Medicare "Doc Pay" Data Being Used to Bolster Fraud Cases: Last year's public release of Medicare payments to physicians ("doc pay") yielded numerous news stories concerning physician salaries. With the recent news of the indictment of a Florida cardiologist whom the media last year publicized as being Medicare's second highest paid physician, physicians worry about doc pay data yielding fraud cases.

Opponents of publicizing the data, including the American Medical Association, argued that it could invade doctors' privacy and be misinterpreted by the public and the media. For instance, in the case of the Florida cardiologist, the reimbursements attributed to him – $18 million – actually reflect payments to his entire practice, which is comprised of 10 doctors in 6 medical facilities, even though the claims were submitted under his individual Medicare number.

Legal experts have repeatedly expressed that billing the federal healthcare program for unusually high sums is not in and of itself an indication of fraud and that the doc pay data is insufficient to lead to a lawsuit against a highly paid doctor. However, that data could be used to bolster cases that whistle-blowers bring to lawyers based on other sources of information. Although the impact of the release of doc pay data remains to be seen, it is clear that it is being used by both lawyers and watchdog groups in a variety of ways and for multiple purposes

False Claims Act Litigation Targets Auditors: The U.S. Attorney for the Northern District of New York announced that the Research Foundation for the State University of New York has agreed to pay $3.75 million to resolve allegations that its Center for Development of Human Services (CDHS) violated the False Claims Act by manipulating audits it performed of federally funded health care programs in NYS. In 2007, the Research Foundation entered into a contract with the NYS Department of Health to review and report to the federal government information concerning eligibility for NYS's Medicaid and Children's Health Insurance Programs (CHIP). These audits, known as the Payment Error Rate Measurement (PERM) and Medicaid Eligibility Quality Control (MEQC) reviews, were designed to measure, among other things, errors in local determinations of which NYS residents were eligible to receive Medicaid and CHIP benefits during the period 10/1/07 through 9/30/08. The settlement resolves allegations that CDHS manipulated both PERM and MEQC audits by prescreening and altering the cases selected for inclusion in what were supposed to be random sample reviews of Medicaid and CHIP eligibility determinations. The government's case was triggered by a whistleblower lawsuit that was filed under the *qui tam* provisions of the False Claims Act, which allows private persons, known as "relators," to file civil actions on behalf of the United States and share in any recovery. The relators in this case will receive $825,000, which is 22% of the settlement proceeds.

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