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## Congress races to meet privacy law deadline

*Failure could turn responsibility over to bureacrats at the Department of Health and Human Services*

Congressional efforts to beat this summer's deadline for passing medical record confidentiality legislation suffered a setback last week when the Senate Committee on Health, Education, Labor, and Pensions postponed consideration of the issue until June 9.

That gives Congress only a few short weeks before and after the July 4th recess to settle the outstanding issues. If Congress fails to pass a bill, the Health Insurance Portability and Accountability Act (HIPAA) of 1996 will pass the torch to the Department of Health and Human Services (HHS), which would have until next year to come up with final regulations on its own. "They are busy drafting those regulations as we speak," says **Don Asmonga**, government relations director at the Washington, DC office of the Chicago-based American Health Information Management Association.

One major stumbling block that surfaced last week was an effort by Sen. Ted Kennedy (D-MA) to make it harder for health care investigators to acquire patient medical records. "The current drafts still allow law enforcement to use tools that don't require judicial oversight such as an administrative subpoena," explains Kennedy aide **Jim Manley**. "There are also no limitations on the use of the information that is gathered."

The Department of Justice (DOJ) is trying to avoid those restrictions. **John Bentivoglio**, Special Counsel for Health Care Fraud at DOJ, recently

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## HCFA selects outside firms to root our health care fraud

Under the auspices of the new Medicare Integrity Program (MIP), the Health Care Financing Administration (HCFA) has selected 12 firms to augment the claims review work formerly done primarily by Medicare carriers.

HCFA is quick to say there are no incentives tied to MIP companies' compensation. Though it's only logical to assume that in order to have their contracts renewed or continued, MIP companies will want to build impressive track records.

The bottom line for providers could be far more

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## OIG tells HCFA to scrutinize hospital readmissions

The Department of Health and Human Services (HHS) Office of Inspector General (OIG) is targeting overpayments for hospital readmissions and urging the Health Care Financing Administration (HCFA) to use peer review organizations (PROs) as a weapon to correct the problem.

HHS Inspector General (IG) **June Gibbs Brown** reignited the debate over the appropriate role of PROs when she issued a report to HCFA May 5 contending that hospital readmissions under the Medicare prospective payment system (PPS) are "a serious quality of care issue" that must be closely monitored by the agency. "The results of our review," Brown added, "demonstrate that HCFA needs to utilize PROs to more actively monitor hospital readmissions to reduce the risk of inappropriate Medicare payments as well as the risk of premature discharges."

HCFA Administrator Nancy-Ann DeParle agrees, saying that under the agency's performance-based

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## Privacy bills

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told the same committee that in many cases DOJ's ability to investigate and prosecute serious crimes — including health care fraud — will turn on its ability to obtain "individually indentifiable health information in a timely and appropriate manner." As an example, he cited the need to conduct "a comprehensive review of patient medical charts" in a potential investigation of a hospital suspected of billing health insurance plans for services that were never provided.

Among the three bills currently vying for the top spot, only the one sponsored by Sen. Patrick Leahy (D-VT) would require law enforcement officers to obtain a court order before gaining access to medical records. Leahy's bill would also prohibit law enforcement agencies from using medical records as part of any centralized law enforcement database. The other two front-runners — bills sponsored by Sen. Robert Bennett (R-UT) and Sen. Jim Jeffords (R-VT) — would give law enforcement much wider latitude.

But that's not the only issue that has Congress stymied. Another key issue is whether or not the bill passed by Congress should override existing state privacy laws. The bills sponsored by Bennett and Jeffords would essentially blast existing state laws, but Leahy's bill would not. Multi-state health care providers say a patchwork of state and federal regulations in this area would spell disaster. Already, they point out, the draft bills each approach 100 pages. And that's before HHS turns those laws into regulations.

A third issue is "private right of action," says Asmonga. "The Democrats want a private right of action where somebody could sue an institution for wrongful disclosure of health information," he reports. "But that is something that is going to be a tough sell in the Republican conference."

At the moment, it's anyone's guess whether Congress will sort these issues out in time to meet the Aug. 21 deadline. If it doesn't, federal lawmakers might try to extend their deadline until the end of the year but the Clinton Administration could always eliminate that option with a Presidential veto. ■

## Privacy experts: Don't wait for final rules, act now

If you're not thinking about and planning for new patient medical record confidentiality legislation, you should be, privacy experts say.

"Institutions need to have policies in place and need to begin thinking about this issue," says privacy expert **Bob Gelman** of Gelman & Associates in Washington, DC. "Much of what a health care institutions will need to do is pretty clear and a fair amount of it can be done — or at least started — right now. They're going to have to do it one way or the other eventually."

That's because Congress is working hard on a set of privacy laws that must be passed by Aug. 21 or the Department of Health and Human Services (HHS) will establish its own set of privacy regulations next year.

"Most health care institutions don't have adequate privacy policies," says Gelman. "They don't understand what kind of records they have, where the information comes from, or where it goes." They often do not have clear rules for regulating its use internally and its disclosure, he adds. "All of these things will be required in some fashion by the legislation or regulations."

**Sandra Fuller** of the Chicago-based American Health Information Management Association (AHIMA) points out that her organization has drawn up just such a list that it is urging providers

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to review. According to AHIMA's "HIPAA Checklist" the first thing providers should do is assign responsibility for tracking the progress of regulations as they develop. AHIMA also recommends these steps:

- Plan internal educational programs to describe HIPAA requirements to those responsible for implementing the changes.
- Perform a gap analysis of existing policies and procedures compared to the requirements of the proposed standards.
- Become familiar with the Notice of Proposed Rule Making for the employer identifier number.
- Become familiar with information security standards and standards development organizations.
- Discuss the proposed requirements with current vendors who may be supporting your organization's information systems.

**Doug Peticord**, a health care information expert with Washington (DC) Health Advocates, reports that one new feature just added to the Senate's privacy bill is the requirement for an Information Protection Officer. "This would mean that every hospital and provider group would have to designate a person with the authority and obligation to establish and maintain safeguards over the confidentiality of patient information," he says.

"I think it is a good idea for every institution to have somebody assume this role right now if they have not already done so," adds Peticord. "Even if this concept gets dropped from the bill itself, it is a step that makes a lot of sense."

Also, the security requirements providers will have to live by have already been outlined under the Health Insurance Portability and Accountability Act of 1996 regulations published as a proposed rule, says Gelman. "Institutions don't have to wait for that to become final because those regulations are probably not going to be much different than the draft regulations," he says. "That is where a lot of time and effort and money will be required."

"It is not just a matter of protecting your patients; it's also [a matter of] protecting yourself," warns Gelman. "Stories about health privacy violations find themselves on the front-page of the local newspaper and it is only a matter of time before institutions get caught or sued — or both." ■

*For AHIMA's complete "HIPAA Checklist," go to www.ahima.org/publications/2a/pract.brief.499.html.*

# Readmissions report

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contracting, PROs will be judged by how successful they are in reaching payment error reduction goals.

The IG's report breathed new life into the dormant debate over the appropriate role of PROs. In May 1998, the OIG issued a directive that tasked PROs with detecting billing errors and reporting those errors to the OIG and other enforcement agencies. But in the face of heavy criticism from the American Medical Association and others, the OIG backed off.

In the report, the OIG recommended that HCFA reinstate hospital readmission reviews under the Payment Error Prevention Program (PEPP) directive and also monitor the fiscal intermediaries' recovery of the $178,741 in improper Medicare payments made in 1996.

DeParle says the recommendation will "will fit in well" with HCFA's current proposal for the PROs next contract. "We are developing a performance-based contract for PEPP and the PROs will be able to consider readmission reviews as part of reaching their goals," she reports.

**Ivy Baer**, an attorney for the American Association of Medical Colleges in Washington, DC, says, "It is a concern when you start using a PRO as a reviewer and a watchdog. I don't think that was the original intent, and I don't think that is the way providers generally view them."

**Mary Grealy**, Washington, DC-based legal counsel to the Chicago-based American Hospital Association, echoes that sentiment and criticizes the limited scope of the study. "The pattern is that these reports look at a very limited sample, then extrapolate to come up with a number about how much money has been lost," she says. "The problem is, until you really dig into these things, you don't know all the reasons a patient may have been discharged. Let's face it, this is not an exact science."

The OIG's report was based on a review of a random selection of 100 hospital readmissions across 18 states. It concluded that 29 of the readmissions were "inappropriate" and said the pricetag of those overpayments was $178,741. Using that number, the IG pegged the cost of inappropriate hospital readmissions in these states at roughly

$22 million in 1996 and said nearly half of the errors were the result of premature discharges.

But DeParle hedges her bet by pointing out that while "a judicious review" of discharge patterns may prompt some PROs to conduct these reviews, in other cases they may not. She says that decision must be left to the discretion of the contractor. ■

# DeParle: Managed care plans 'gaming the system'

Based on a new study of alleged overpayments to hospitals owned by managed care companies, HCFA administrator **Nancy-Ann DeParle** has accused managed care plans of "gaming" the Medicare system. Deparle adds that the agency will step up its investigations in this area.

Department of Health and Human Services (HHS) Inspector General (IG) **June Gibbs Brown** delivered the report to DeParle May 16. It charges that between 1991 and 1996 Medicare overpaid hospitals at six managed care firms by more than $200 million for inpatient services furnished to beneficiaries who had disenrolled from managed care risk plans.

According to the IG, Medicare paid hospitals $224 million for these services instead of $20 million in capitation payments which these hospitals would have received had these beneficiaries not disenrolled.

According to DeParle, managed care plans may be attempting "to avert their own costs at a high cost to the Medicare program." She also agreed there was a problem with disenrollment "just prior to receiving expensive inpatient services" and concluded these findings "suggest the need for further investigations" and "careful monitoring of the managed care environment." ■

# MIP program

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aggressive investigators and investigations, some observers conclude.

HCFA got the go-ahead to hire those contractors under the Health Insurance Portability and Accountability Act (HIPAA) of 1996. Since then, many have expressed concerns that these companies will be super-charged to turn up fraud. But HCFA insists there will be no incentives tied to their compensation.

HCFA has been "fairly successful" in rooting out fraud over the last few years but now the agency wants to push the ball even further, says HCFA spokesman **Craig Polaski**. "These new contractors are part of that overall effort to try to tackle this problem."

Health care attorney **Sandy Teplitzky** says the jury is still out on how zealous the new contractors will be. "To the extent that the contractors provide clear guidance regarding the law and investigative and enforcement initiatives that are consistent and fair, I don't think that anybody is going to have a real concern with this move," said Teplitzky, of the Baltimore law firm Ober, Kaler. "But it is critical that these firms have experience in the health care field and understand the reimbursement methodologies used by the federal health care program."

"This is the first time we have done this," Polaski adds. "These 12 contractors will become our new partners and can help us do things in a way that are different than in the past."

An outline of the Administration's FY 2000 budget package would reportedly add collection of Medicare overpayments to the list of activities eligible for MIP dollars. The outline does not explain how HCFA would utilize the MIP money for collection activities, although Medicare contractors would presumably use the funds to further beef up recoupment efforts. ■

## HCFA's 12 MIP Contractors

- Aspen Systems, Rockville, MD;
- Blue Cross/Blue Shield of Alabama, Birmingham;
- Computer Sciences Corp., Falls Chaurch, VA;
- California Medical Review, San Francisco;
- DYN Corp., Reston, VA;
- Electronic Data Systems, Plano, TX;
- Lifecare Management Partners, Inc., Alexandria, VA;
- Reliance Safeguard Solutions, Inc., Syracuse, NY;
- Regence Blue Cross/Blue Shield of Utah, Salt Lake City;
- Science Applications International Corp., Vienna, VA;
- Tri-Centurion, LLC, Columbia, SC;
- United Government Services. Milwaukee. ■