POLICY & PRACTICE

Vermont Bans Most Pharma Gifts

Vermont Gov. Jim Douglas (R) has signed into law a bill that prohibits manufacturers of drugs, medical devices, and biologics from providing free gifts, including meals and travel, to physicians and other health care providers. The toughest of its kind in the nation, the legislation also requires disclosure of any allowed gifts or payments, regardless of their value. In 2002, a Vermont law required disclosure of gifts or payments of $25 or more. Under the stronger law, manufacturers can give physicians only gifts such as samples intended for patients, "reasonable quantities" of medical device evaluation or demonstration units, and copies of peer-reviewed articles. They still can provide scholarships or other support for medical students, residents, and fellows to attend educational events held by professional associations, as long as the association selects the scholarship recipient.

More Flu Preparation Needed

Federal and state governments need to do more to prepare for possible pandemic flu, the Government Accountability Office (GAO) said after reviewing the H1N1 flu outbreak. The office acknowledged pandemic planning throughout government but said that more efforts are needed to improve disease surveillance and detection, address issues of coordination between various governmental entities, and improve capacity for patient care in the event of a pandemic. The GAO warned that the H1N1 virus could return next fall or winter in a more virulent form. Meanwhile, a Robert Wood Johnson Foundation report on the recent H1N1 outbreak concluded that health officials reacted effectively but noted that public health departments often did not have enough resources to carry out plans. The report also urged improvements in the ability of providers to manage a massive influx of patients.

Minorities Face Miscommunication

Black, Hispanic, and Asian patients are more likely than white patients to report problems communicating with their physicians, the Agency for Healthcare Research and Quality said. The AHRQ found that 13% of black and Asian patients, and 12% of Hispanic patients, said they had trouble communicating with their doctors in 2005, compared with 9% of whites. Roughly twice as many poor people as high-income people, regardless of their race or ethnicity, reported communication problems.

Bankruptcies, Illness Linked

Medical problems contributed to nearly two-thirds of all bankruptcies in the United States in 2007, according to a study in the American Journal of Medicine. Based on court-record reviews and interviews of more than 2,300 bankruptcy filers in 2007, the study found that 62% of filers cited medical debts and income lost to illness as reasons for seeking bankruptcy. Of these "medically bankrupt families," 9 out of 10 said they had medical debts over $5,000, and the rest met criteria for medical bankruptcy because they had lost significant income because of illness or mortgaged a home to pay medical bills. Out-of-pocket medical costs averaged $17,943 for all medically bankrupt families, including the three-quarters of families that had insurance at the outset of their problems. Most medical debtors were well educated, owned homes, and had middle-class occupations, the study found.

Medical Homes, Clinics Urged

A series of innovations, including patient-centered medical homes and retail clinics staffed by nurse practitioners and physician assistants, would help transform the primary care system into one that is higher in quality and more effective, according to a report from the Massachusetts-based New England Healthcare Institute. The report noted that "the promise of a high-quality primary care system has remained largely unfulfilled" but said the current crisis in primary care offers an opportunity for change. In addition to urging adoption of the medical home model and retail clinics, the institute recommended such changes as shared medical appointments, open-access scheduling, more work site wellness programs, and primary care home visits. The report said that improvements in health information technology could free physicians to spend more time with patients.

ED Overcrowding Continues

The emergency department wait time to see a physician for emergent patients—those who should be seen in 1-14 minutes—averaged 37 minutes in 2006. Half of such patients waited longer than recommended, the GAO said in a report. In addition, patients who should have been seen immediately waited an average of 28 minutes, and about three-fourths had to wait to be seen. Hospitals performed better with urgent cases: Those patients, who should be seen in 15-60 minutes, waited an average of 50 minutes, and only about 20% waited longer than recommended, the report said. Lack of inpatient beds continues to be the main driver of ED overcrowding. ED boarding of patients who are waiting for an inpatient bed continues to be a problem, the GAO noted. The American College of Emergency Physicians warned that overcrowding and wait times will only get worse as the population ages. "People age 65 and older represent the fastest growing segment of the population and the group whose visits to the emergency department are increasing the fastest," Dr. Nicholas Jouriles, ACEP president, said in a statement.

—Jane Anderson

Medicare RAC Program Will Start This Summer

BY DENISE NAPOLI

WASHINGTON — Physicians and other providers in certain states are beginning to receive demand letters from Medicare Recovery Audit Contractors, Dr. Thomas Valuck said at a meeting of the Practicing Physicians Advisory Council.

Officials from the Centers for Medicare and Medicaid Services will begin to roll out the program to the rest of the country later this summer, with demand letters reaching providers in August or early September, according to Dr. Valuck, medical officer and senior adviser at the Center for Medicare Management.

RACs can audit any Medicare fee-for-service claims up to 3 years from the payment date, but during the program's early phase will review only claims made on or after Oct. 1, 2007.

The Recovery Audit Contractor (RAC) program is designed to identify and correct past improper Medicare payments, including underpayments. It began as a demonstration project in California, Florida, and New York in 2005, and was made permanent and nationwide in 2006 by the Tax Relief and Healthcare Act. It is administered by private contractors who collect a fee based on the errors they detect.

The RACs—which have access to Medicare fee-for-service claims data—use software to analyze claims for inaccuracies regarding coding, billing, and payment. Beginning in September, the RACs will also conduct computer-facilitated "complex reviews" on diagnosis-related group (DRG) coding errors, said Cmdr. Marie Casey, USPHS, CMS deputy director of recovery audit operations. And by 2010, in addition to these audits, the RACs will also review the medical necessity of certain claims. Such reviews will rely on the expert medical opinion of physicians and other medical professionals who work for the RACs. Cmdr. Casey added that the RACs can audit any Medicare fee-for-service claims up to 3 years from the payment date, but during the program's early phase will review only claims made on or after Oct. 1, 2007.

Cmdr. Casey and her colleague Lt. Terrance Lew, USPHS, a health insurance specialist at the division of recovery audit operations at the CMS, offered the following advice for preparing for an RAC review:

► Know where previous improper payments have been found so that you can avoid making the same mistakes. This information is available at www.cms.hhs.gov/RAC/Downloads/RAC%20Evaluation%20Report.pdf.

► "Make sure that you're in compliance with all the applicable Medicare policies, coverage determinations, coding directives, requirements for documentation," Lt. Lew advised.

► Identify key RAC contacts. (See box.) Each region has its own RAC (www.cms.hhs.gov/RAC/Downloads/Four%20RAC%20Jurisdictions.pdf).

► Develop processes for tracking and responding to RAC requests and demand letters. "There are timelines attached to demand letters," Lt. Lew said. "Have a system for tracking those timelines."

► Appeal when necessary. "If you make a business decision that an appeal is warranted, we would certainly encourage you to appeal," Lt. Lew said. ■

For more information about the RAC program, visit www.cms.hhs.gov/RAC.

Get Ready for the RAC in Your Region

Outreach designed to educate providers about the RAC program and what to expect is still being conducted in Regions B and D, and the CMS soon will begin outreach in Region A. The updated provider outreach schedule can be found at www.cms.hhs.gov/rac.

Provider outreach must occur in each state before an RAC is authorized to send any correspondence to a provider, such as a demand letter for recoupment or a request for additional documentation.

The RACs will begin with very basic "black and white" reviews, Cmdr. Casey said, adding that these reviews will be performed on an automated basis (no medical records are required).

Starting as early as September, the RACs may begin reviewing coding issues and diagnosis-related group validations, which will require the review of additional documentation.

Once the RAC has been established in the region, the RAC may begin to review claims for medical necessity.

To contact the RAC for your region:

► **Region A:** Diversified Collection Services (DCS), 866-201-0580; www.dcsrac.com.

► **Region B:** CGI, 1-877-316-7222; http://racb.cgi.com; racb@cgi.com.

► **Region C:** Connolly Consulting Inc., 866-360-2507; www.connollyhealthcare.com/RAC; RACinfo@connollyhealthcare.com.

► **Region D:** HealthDataInsights Inc., 866-590-5598 (Part A); 866-376-2319 (Part B); racinfo@emailhdi.com.