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INTRODUCTORY REMARKS
October 20 HCR Webinar

Thank you for joining us for the fourth in our series of health reform webinars. My name is Dr. Jerry Joseph, Immediate Past President of ACOG, and joining me again today is Lucia DiVenere, ACOG's Senior Director of Government Affairs.

Our intent in offering this series is to give you detailed practical information about the new health reform law, including changes that will affect your practices and your patients. Before we start, let me review a few "housekeeping" points:

- If you're listening in by phone, please be sure to **mute** your line for everyone's benefit.
- You can submit **questions** throughout the webcast, using the form shown on your screen. We'll answer your questions at the end, and please include your **email address** so we can get back to you if we run out of time.
- If you experience any **technical issues** during the webcast, please use the help button shown on your screen.
- Please note that these slides are available for download at ACOG's health reform center at www.acog.org.

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Upcoming Webinars

Before we get started on today's subject, listed here are the subjects and dates of our future webinars.

Please note that the November session will be held on Wednesday, November 10th, at Noon ET.

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There's special emphasis on compliance in the Affordable Care Act, and maybe for good reason. Compliance means playing by the rules. Compliance programs are designed to help eliminate fraud and abuse.

Medicare and Medicaid together make up the single largest purchaser of health care in the world, representing more than 20% of all US federal spending.

The FBI estimates that public and private health care fraud may account for up to 10% of all US health spending. And most observers acknowledge that the problem with our health care system isn't that we're not spending enough money, we're spending plenty, but we may not be spending it as wisely as we could or should.

Congress put measures in place in this law to make sure we get our dollars' worth.

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The first compliance change takes place this year, as the Recovery Audit Contractors program, known unaffectionately as the RAC, expands to the Medicaid program.

Under this program, begun in 2003 in the Medicare program, independent contractors are paid to go into practices and look for over or inappropriate payments, after claims are paid. Contractors are paid an average of 12.5% of the money they recover, a strong incentive for them to find problem payments. Lucia, provide us with some numbers for reference.

In 2008, the RACs identified more than a $1 billion dollars in improper Medicare payments, 96% of which were overpayments. The 4% underpayments were repaid to the providers.

Physician payments accounted for only 2% of improper claims, 85% were found in hospitals. And of all improper claims, 40% were for medically unnecessary care and 35% were incorrectly coded.

I encourage all practicing ob-gyns to pay special care to these audits. Follow ACOG's guidelines for no inductions before 39 weeks without clinical indication, and stay on top of your coding practice.

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We'll see two compliance provisions come into effect in 2011, only one which may affect some of us.

First, exceptions to the current ban in self-referral will be tightened. This change may be invisible to most of us and likely not affect your practices.

Congress passed this legal prohibition on physicians referring patients to hospitals in which they have a financial interest a number of years ago. The intent is to protect patients from a physician's conflict of interest, in cases where the physician would stand to profit from his referral.

The Affordable Care Act tightens exceptions to this prohibition. Lucia, please tell us how.

In order for a hospital to qualify for an exception to the self-referral ban, it will have to disclose the physician/hospital financial relationship in any ads it runs and on its website, and that it has measures in place to prevent conflicts of interest.

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Physicians and other providers will have to meet new compliance criteria in order to participate in the Medicare, Medicaid and CHIP programs.

These new criteria could range from criminal background checks, unannounced visits, fingerprinting and more. To me as a practicing physician, this sounds ominous and even threatening, Lucia, what's does this mean to all of us?

The law specifies that these new requirements must be applied to health care sectors according to risk of fraud and abuse. This month, the US Department of Health and Human Services published proposed regulations to carry out this section of the law, and categorizes physicians as "limited," meaning low, risk.

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This means that HHS is proposing that physicians, medical groups, and clinics would only have to:

Verify that you meet federal and state requirements

Verify that you meet licensure requirements and

Allow periodic database checks to show that you continue to meet these criteria.

These rules, if they become final, would apply to newly enrolling physicians beginning March 23, 2011 and to currently enrolled physicians one year later, March 23, 2012.

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New rules shed light on transfers of value – those pens, trips, meals, sponsorship at meetings, anything we get from manufacturers that has a dollar value -- from manufacturers to physicians and teaching hospitals.

Beginning in 2013, manufacturers will have to publicly report all transfers of value to physicians and teaching hospitals, except:

- Items valued at less than $10, unless over a calendar year these transfers add up to more than $100
- Dividends and profit distributions
- Product samples
- Device loans and
- In-kind charity contributions

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Manufacturers will also have to report any physician ownership or investment, except for publicly traded securities.

And all reported transfers and ownership and investment information will be made public, giving physicians 45 days to review and correct information related to them before it's posted.

It's important to remember that the reporting requirements and penalties for noncompliance apply only to manufacturers; there are no physician requirements in this section.

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The Department of Health and Human Services, in the same proposed regulation we discussed earlier, also proposed that providers involved in the Medicare Medicaid and CHIP programs be required to have and use “compliance programs” as a condition of participation.

HHS intends to publish a separate regulation on this at some point in the future, but asked for comments on the idea and what elements should be contained in an approved compliance program.

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HHS is considering requiring that every Medicare Medicaid and CHIP provider would have in place compliance programs that

Follow written policies and standards of conduct.

Identify a chief compliance officer with direct report to the CEO.

Hold regular training for all employees and provided whistleblower protections for its employees.

Have a system to investigate allegations and act on violations,

And work to correct systemic problems.

There is no date for implementation of this proposal yet. At this point, HHS is running it up the flag pole.

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That brings us to the end of our 4th webinar in this series. I hope it's been helpful and informative.

Please type in any additional questions and submit them now with you e-mail address in case we do not have time to answer them before time expires.

Remember that these slides can be found on ACOG's Health Reform Center at ACOG's home page-----www.acog.org, where our webinars are archived and can be viewed at any time.

I hope you'll join us for Session 5 on Opportunities on Wednesday November 10th at Noon ET. Thank you for being with us today.