

INSIDE

Health Care Management News

INSIDE THIS ISSUE:

<i>Individual Health Insurance Plans</i>	1
<i>Mobile Electronic Medical Records</i>	2
<i>ePrescribing Further Pushes eHealth</i>	2
<i>Physician Pay for Performance</i>	3
<i>Medicaid Fraud and Abuse Enforcement</i>	3
<i>About Us</i>	4

Special points of interest:

- Demand is increasing for Individual Health Plans.
- Patients want personal health records.
- Medicare Part D plans leading the eHealth push.
- Pay for Performance programs gaining popularity.
- The government is focusing more on fraud.

TRENDS TO WATCH IN 2006

CHANGES DEVELOPING IN HEALTH CARE

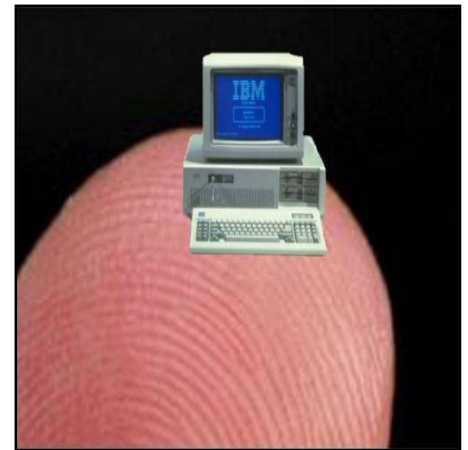
Changes for 2006 are already occurring on every front in health care. Access to information and data sharing is driving the evolution of systems and operations.

Paper is out and the digital age is rapidly advancing into the practice of medicine. Remember prescription pads, medical charts, lab slips, sign-in sheets, and Explanation of Benefit Statements (EOBs)? In 2006 watch for advances in ePrescribing, Mobile Electronic Medical Records, Regional Health Information Organizations (RHIOs), Data Sharing and Data Mining.

Look for exploding growth in Individual Health Insurance coverage and Health Savings Accounts. Increased attention on Physician Pay for Performance Programs and Medicaid Fraud and Abuse enforcement. In medicine, Complementary Medicine is being increasingly accepted by health plans and the medical community, Employers and Insurance Plans continuing a strong push for nutrition, health, and preventative care.

Various flavors of Prescription Drug Plans offered will be seen as the biggest thing since sliced bread. Big getting bigger with more mergers and acquisition activity expected in the insurance market. Disease Management Programs continuing to rise and HMO enrollment further dropping.

This edition of "Inside" summarizes some of the expectations to come and what promises to catch the headlines as we move into 2006.



INDIVIDUAL HEALTH INSURANCE PLANS

INCREASING DEMAND MEANS MORE PLAN OPTIONS

Due to the slowdown in the issuance of group insurance policies the Insurance companies are investigating additional coverage they can offer. Insurance Companies are finding there is an increasing market demand for individual medical insurance coverage.

These Individual plans target the escalating pool

of working uninsured, self-employed, students, recent college graduates, early retirees, and people between jobs.

The U.S. Census Bureau reported that 9.3% of the total insured are covered by plans purchased directly by an individual. The plans varied and included the range of HMOs, PPOs,

POS, and Fee-for-Service plans.

Most of these individual plans had only basic coverage. However, expect with growth in small businesses, part-time employees, layoffs and slowdowns, these plans will rise in 2006. Watch for a variety of options on the horizon.

MOBILE ELECTRONIC MEDICAL RECORDS

PATIENTS WANT PERSONAL HEALTH RECORDS

We live in an increasingly mobile society where as Americans we readily crisscross the globe, effortlessly sending information by email, mail or telephone. We share data seamlessly for business or pleasure. Research any topic with a few keystrokes. We store and carry data using IPODs, MP3 players, Cruzers, and Flash Cards. When it comes to health care, our data is virtually unavailable and definitely not portable. Tucked away in our physicians' offices or stored in the records department at our local hospital. Often patient records are not centralized or complete at any one location.

In the case of emergencies, patients are often times treated without vital information. At such times, the risk of medical error spikes dangerously.

Even though chip-embedded smart cards have not lived up to their promise, a variety of new products is emerging—from USB-enabled key chains containing health records to Web-based solutions. Among the simplest solutions—are portable CD-ROM disks that give patients control of their records.

According to a recent Web survey, released this week by the IT and Research group Accenture, consumers are willing to pay as much as

\$60 a year for a personal EMR solution.

Several companies, including [FollowMe](#), [Red-Medic](#), [MedicAlert](#) and [CapMed](#) already let customers manage their medical information online. Most charge approximately \$30 a year. Some charge more and provide other services, such as specialized flash drives. Whatever the method, patients are demanding access. Expect this push to continue.



More than three billion prescriptions are written and 65% of the population use prescription medications in the United States each year.

E-RESCRIBING FURTHER PUSHES EHEALTH

MEDICARE PART D PLAN CHANGING THE HORIZON

Electronic communication continues to be pushed to the forefront by the Department of Health and Human Services (HHS).

In early 2005, the HHS sought input into the development of a national health information network.

In April 2005 the Health Insurance Portability and Accountability Act's (HIPAA) Security Rule became enforceable.

HHS is now pushing eHealth through the adoption of standards for electronic prescriptions or "ePrescribing" under the Improvement and Modernization Act of 2003 (MMA), requiring all par-

ticipants of the Medicare Part D drug program to comply with the ePrescribing standards.

MMA is even requiring the Secretary of HHS to promulgate an anti-kickback statute safe harbor and an exception under the Stark legislation for certain non-monetary remuneration relating to ePrescribing information technology items and services!

The HHS also recently awarded four contracts for development of prototype national health information networks. The department expects the prototypes to be delivered in the fall, then scaled up in 2007

ePrescribing stan-

dards are predicted to be the first program to impact our health care system dramatically.

National standards for ePrescribing are an important step in that process, and stakeholders in the ePrescribing process, including pharmacy benefit managers, pharmaceutical manufacturers and vendors, physicians, pharmacies and pharmacists, should monitor the MMA ePrescribing rules and related state legislation.

All Health Care providers should actively advocate for rules that will promote an efficient and effective eHealth infrastructure.

Ready or not, eHealth is embraced by the government and is here to stay.

PHYSICIAN PAY FOR PERFORMANCE

THEORY THAT OUTCOMES INFLUENCE COST

Physician Pay for Performance (PFP) programs are incentive programs being offered to providers by health plans, coalitions, insurance companies, and employers. These PFP programs provide additional compensation to physicians who achieve, or make progress toward a defined benchmark or measurement.

The underlying theory is that as quality increases, the nation's health improves and health care costs decrease.

Two organizations that have evaluated and proposed the guidelines and implementation process for the PFP programs are:

- American Medical Association (AMA)

- The Centers for Medicare and Medicaid Service (CMS)

In 2006 watch for more Medicare initiatives to encourage improved quality of care in all health care settings where Medicare bene-



ficiaries receive their health care services, including physician offices, ambulatory care facilities, hospitals, nursing homes, home health care agencies and dialysis facilities.

The foundation of effective PFP initiatives is encouraging cooperation with

providers and other stakeholders to ensure that there are reasonable and fair standards used. That providers aren't being pulled in conflicting directions, and that providers have support for achieving improvements.

Consequently, to develop and implement these initiatives, CMS is collaborating with a wide range of other public agencies and private organizations who have a common goal of improving quality and avoiding unnecessary health care costs. CMS is also providing technical assistance to a wide range of health care providers through its Quality Improvement Organizations (QIOs). Expect more attention on this subject in 2006.

Health care providers need in place an effective compliance Program, and remain vigilant in identifying and correcting potential Medicaid compliance problems.

MEDICAID FRAUD AND ABUSE ENFORCEMENT

GOVERNMENT REPORT DETAILS OIG FOCUS

According to a recent government report and proposed federal legislation, expect an increase in Medicaid Fraud and Abuse enforcement in 2006.

Health care savings and recoveries from Medicaid fraud were at the highest in 2005 and the push is on for more. The funds are reportedly from settlements, judgments, and administrative penalties. The Office of Inspector General (OIG) has been recovering substantial sums of money from both large and small health care providers based typically on allega-

tions of Medicaid fraud and abuse. The report also details that funds are allocated to Centers for Medicare and Medicaid Services (CMS) specifically to combat fraud in Medicaid and the State Children's Health Insurance Program (SCHIP).

In addition, a bill was proposed that would give states a direct financial incentive to enact state false claims statutes and to pursue state false claims cases. This bill also provides that the state false claims laws do not have to be limited to Medicaid fraud, so states may choose to apply the



laws more broadly. In addition, the legislation would increase spending for Medicaid fraud and abuse control activities. This includes an additional \$25 million each year beginning in 2006 through 2010 for Medicaid activities of the OIG. The bill would also establish a Medicaid Integrity Program, much like the Medicare Integrity Program.

The Ricardo Group, Inc.

NEW ADDRESS!
4012 S. Rainbow Blvd.
Suite K
Las Vegas, NV 89103

Phone: (702) 252-0969
Fax: (702) 987-0256
Info@RicardoGroup.com

We're on the Web!
www.RicardoGroup.com

*Experts in Health Care
Management,
Litigation Support, and
Appraisals*

Editorial Staff

Ralph C. Wolf

Ralph@RicardoGroup.com

Maryann (Ricardo) Wolf

MsWolf@RicardoGroup.com

**I didn't
know The
Ricardo
Group, Inc.
did that!**

THE RICARDO GROUP, INC.

DID YOU KNOW.....

The Ricardo Group, Inc. is a nationally recognized and respected health care management consulting firm that continues to stay abreast of leading edge issues and changes. As healthcare management specialists one of our traditional strengths have been our ability to offer a full spectrum of healthcare business consulting, litigation support, and valuation services.

The Ricardo Group, Inc.'s pioneering approach to resolving the fiscal dilemma facing many of today's Physicians and Associated Organizations continues to gain widespread acceptance.

TRG Services include:

- Forensic Accounting and Litigation Support.
- Expert Witness Testimony.
- Physician Recruitment and Relocation.
- Market Needs Assessment including MUAs and HPSAs.
- Group Practice Formation and Partnership Plans.
- Business Plan Development.
- Structuring for Venture and Traditional Financing.
- Litigation and Divorce Valuations.
- Medical Staff Planning
- Hospital Sponsored Physician and Residency Training Seminars.



Experts in Health Care Management, Litigation Support and Appraisals.

TRG Clients Include:

For-Profit and Non-Profit Hospitals, Physicians, Medical Groups, Management Service Organizations (MSOs), Independent Physician Associations (IPAs), Surgery Centers, Billing Services, Medical and Specialty Societies, Health Maintenance Organizations.