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In this issue

CMS Regulatory Updates: 2009 IPPS Rule Finalized [Full Article]

In the August 19, 2008 copy of the Federal Register,[1] CMS finalized many of the provisions found in the 2009 Inpatient Prospective Payment System Proposed Rule.[2] Notably, CMS finalized its proposals regarding the *"stand in the shoes"* provision, the prohibition of *"per click"* leasing arrangements and percentage based rent, and the expansion of the definition of "entity" to include under arrangement service providers.

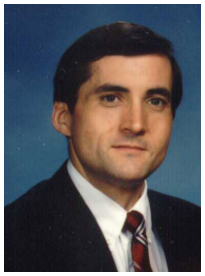
"Stand in the Shoes" Provision

In the 2009 Inpatient Prospective Payment System Final Rule (Final Rule)[3], CMS has issued a more straightforward approach to the *"stand in the shoes"* doctrine than it had previously proposed. Under the final *"stand in the shoes"* provision, CMS elected to apply the mandatory provision only to physicians with an ownership or investment interest in the physician organization, and only where that interest includes the ability or right to receive financial benefits.[4] However, in situations where a physician organization has both owner and non-owner physicians, the Final Rule allows Designated Health Services (DHS) entities to treat the non-owner physicians as standing in the shoes of the physician organization so that two different compensation analyses are not required.[5] Also excepted from the provisions are arrangements which meet the requirements of the academic medical centers exception.[6] Additionally, CMS chose not to finalize the proposed rule that would have required a DHS entity to *"stand in the shoes"* of any organization in which it had a 100% ownership interest. This decision is the result of CMS' desire to make the Final Rule as straightforward as possible by eliminating the necessity of determining the order in which to apply the *"stand in the shoes"* provisions.

Growing Support of Gainsharing Arrangements [Full Article]

In the CY 2009 Proposed Physician Fee Schedule, promulgated on July 7, 2008,[1] the Centers for Medicare and Medicaid Services (CMS) proposed a new exception to the Stark law for certain incentive payment (i.e. Pay for Performance) and shared savings programs, including gainsharing arrangements. *Gainsharing"* is defined by CMS to be an arrangement *"under which a hospital gives physicians a share of the reduction in the hospital's costs (that is, the hospital's cost savings) attributable in part to the physician's efforts."*[2] Historically, gainsharing arrangements were found to violate the Civil Monetary Penalty Statute and the Anti-Kickback Statute, despite potential cost-saving benefits of well-structured arrangements.[3] In 2005, however, the Office of Inspector General (OIG) began to approve gainsharing arrangements in light of their cost-saving and quality improving potential, despite the fact that the basic arrangements themselves were still technical violations of the statutes, reasoning that the potential for fraud was reduced when certain safeguards were present. In those that arrangements that it approved, the OIG looked for three types of safeguards: (1) measures that promote accountability and transparency, (2) adequate quality controls, and (3) controls on payments related to referrals.[4]

Following the lead of the OIG, CMS has now recognized that *"successful programs often result in improved quality outcomes or cost savings (or both) for the hospital sponsoring the program."*[5] Since the arrangements involve making payments to physicians whose efforts contribute to these successes, however, the self-referral statute (Stark Law) can often be implicated. The concern is that *"improperly designed or implemented programs pose [a high risk of*



Robert James Cimasi, MHA ASA, CBA, AVA, CM&AA, CMP President Robert James Cimasi is a nationally recognized healthcare industry expert, with over twenty years experience in serving clients, in over forty five (45) states, with a professional focus on the financial and economic aspects of healthcare industry including: valuation consulting; litigation support & expert testimony; business intermediary and capital formation services; certificate-of-need and other regulatory and policy planning; and, healthcare industry transactions, joint ventures, mergers and divestitures.

Mr. Cimasi holds a Masters in Health Administration from the University of Maryland, and several professional certifications. He has been certified and has served as an expert witness on cases in numerous states, and has provided testimony before federal and state legislative committees.

Mr. Cimasi is a nationally known speaker on healthcare industry topics, is the author of several nationally published books, chapters, published articles, research papers and case studies, and is often quoted by healthcare industry press. Mr. Cimasi's latest book, The U.S. Healthcare Certificate of Need Sourcebook, was published in 2005 by Beard Books. In 2006, Mr. Cimasi was honored with the prestigious Shannon Pratt Award in Business Valuation conferred by the Institute of Business Appraisers and was elevated to the Institute's College of Fellows in 2007.

Todd A. Zigrang, MHA, MBA, CHE Senior Vice-President Todd Zigrang has over twelve years experience in providing valuation, financial analysis, and provider integration services to HCC's clients nationwide. He has developed and implemented hospital and physician driven MSOs and networks involving a wide range of specialties; developed a physician-owned ambulatory surgery center; participated in the evaluation and negotiation of managed care contracts, performed valuations of a

Prohibition of "Per-Click" Arrangements and Percentage Based Rent

CMS also finalized its proposal which prohibits basing the charge for rented space and equipment on a *"per-click"*, or per-unit basis, i.e. , physicians and DHS entity lessors may not charge physician lessees rent based on the number of services provided by the lessees which are referred to them by the lessors. This limitation is imposed under the space and equipment lease exception to Stark, the fair market value exception, and the indirect compensation arrangement exception.[7] CMS concluded that *"on demand"* time-based rental arrangements are also considered per-click arrangements and therefore fall under the limitation, as well.[8]

Similarly, CMS finalized the rule it had proposed which prohibits rental charges based on a percentage of revenues earned in the rented space or with the rented equipment, regardless of whether the services were referred from the lessor.[9] Excluded from this prohibition are arrangements where physicians pay on a percentage basis for management and billing services. CMS also declared that the rule would not prohibit gainsharing arrangements, as long as they are properly structured incentive payment and shared saving programs.[10] While the rule has been finalized, the potential need for restructuring has led CMS to delay the implementation of these *"per-click"* limitations until October 1, 2009.

CMS Expands Definition of "Entity" to Include Under Arrangement Service Providers

Also part of the 2009 IPPS Final Rule, CMS included a provision which changes the framework of *"under arrangements"* such that both the physician-owned entity which provides the service, as well as the hospital which bills for the service, are considered DHS entities for purposes of Stark law.[11] The result of this provision is that it will preclude physician-owned entities from performing services on hospital patients *"under arrangements"* with the hospitals unless the physician-owner(s) can satisfy the ownership exception under Stark. CMS concluded that any entity that performs a service under arrangement for a hospital which is then billed by the hospital is now considered a DHS entity, even if that service would not have been considered a DHS entity if the service was done outside the hospital setting. The only exception to this

program or patient abuse]," and that *"additional risk is posed by [gainsharing arrangements] that reward physicians based on overall cost savings without accountability for specific cost reduction measures."*[6] Potential problems include physicians engaging in stinting, cherry picking, steering, and quicker-sicker discharge behaviors.[7]

Recognizing the potential for abuse, but also the potential to improve quality and cost effectiveness, the proposed exception to the Stark Law for properly structured gainsharing arrangements focuses on three crucial aspects: transparency, quality controls, and safeguards against payments for referrals.[8] The proposed rule would:

(1) Apply to a wide variety of gainsharing program structures, but only those which are implemented by a hospital (though CMS is also soliciting comments on how such arrangements could work when implemented by other DHS entities);
(2) Protect remuneration only in the form of cash (or cash equivalent) payments made by a hospital, and only payments made to physicians who actually participate in the achievement of the patient care quality measures or cost savings measures that are the subject of the particular program; and,
(3) Allow payments to be made to participating physicians individually or to physician organizations composed entirely of participating physicians, where participating physicians would receive shared savings payments on a *per capita*basis (CMS is further considering whether to include under the exception physicians in the "qualified physician organization" who choose not to participate in the gainsharing program); also, the rule would not protect physicians who merely refer patients to the hospital but do not otherwise participate in the program.

Nothing in the proposal would limit or prohibit non-physician practitioners from participating in shared savings programs, as they are not covered by Stark Law.

To be protected under the exception, a shared savings program *"must be a documented [in writing] program that seeks to achieve the improvement of quality of hospital patient care services through changes in physician clinical or administrative practices or actual cost savings for the hospital resulting from the*

wide array of healthcare entities; participated in numerous litigation support engagements; created pro-forma financials; written business plans and feasibility analyses; conducted comprehensive industry research; completed due diligence analysis; overseen the selection process for vendors, contractors, and architects; and, developed project financing.

Mr. Zigrang holds a Masters in Business Administration and a Master of Science in Health Administration from the University of Missouri at Columbia. He holds the Certified Healthcare Executive (CHE) designation from, and is a Diplomat of, the American College of Healthcare Executives and a member of the Healthcare Financial Management Association.

Lance A. Haynes serves as a Vice President of Health Capital Consultants (HCC) in the area of financial and economic analysis and consulting. His main responsibilities are comprised of business, tangible asset and intangible asset valuations, as well as financial analysis and forecasting for healthcare services related enterprises. Mr. Haynes has performed valuations for many types of ancillary services providers including Surgical/Specialty Hospitals and Ambulatory Surgery Centers, Cardiac Catheterization Labs, Diagnostic Imaging Centers and Kidney Dialysis Centers, and has also performed valuations and financial analyses for Home Healthcare Providers, Long-term Care Facilities and Physician Medical Practices across various specialties. In addition, Mr. Haynes has performed joint venture service line and lease arrangement valuations for hospitals and physician groups, and has assisted with numerous litigation support engagements. Prior to joining HCC, Mr. Haynes was a Research Associate with Flagstone Securities, a specialty investment bank, located in St. Louis, Missouri, where his main responsibilities included the development and maintenance of company earnings models and proprietary stock indices related to publicly traded companies.

Mr. Haynes received his Bachelor of Arts in Finance from the University of Northern

final conclusion is for lithotripsy services.[12] This provision, as it will also require time for restructuring of arrangements, will also not be implemented until October 1, 2009.

Changes to Incident-to Billing Rules Rescinded

Earlier this summer, after significant pressure from physician organizations and physician advocates, CMS decided to rescind Transmittal 87 concerning its *"incident-to"* billing rules.[13] While CMS felt that the changes would only make the incident-to billing rules, clearer, many physician advocate groups challenged the transmittal for substantive changes it would impose. *"Incident-to"* billing has traditionally been a way for physicians, particularly family care physicians, to be reimbursed by Medicare for services provided under their supervision by non-physician practitioners.[14] Under the proposed changes, there would have been more influence given to Medicare contractors over decisions concerning which services can be billed incident to a physician's care; the definition of *"clinic"* would have been modified such that only services provided incident to physician care in physician owned and operated clinics would be reimbursed; and, burdensome documentation requirements would have been imposed, including the requirement that all non-physician practitioners include their credentials in every patient's medical file.[15] While rescinding the changes presented in Transmittal 87, however, CMS has indicated that it could present other changes to the incident-to billing rules in the future.

[1]73 Fed. Reg. 48433 (Aug. 19, 2008).
[2]73 Fed. Reg. 23528 (April 30, 2008).
[3]73 Fed. Reg. 48433 (Aug. 19, 2008).
[4]"Stark Rule Proposals Finalized," By Cathy Dunlay and Kevin Hilvert, Schottenstein Zox & Dunn Resources, 8/13/08, http://www.szd.com/resources.php?NewsID=1184&method=unique (Accessed 8/14/08)
[5]"Stark Rule Proposals Finalized," By Cathy Dunlay and Kevin Hilvert, Schottenstein Zox & Dunn Resources, 8/13/08, http://www.szd.com/resources.php?NewsID=1184&method=unique (Accessed 8/14/08).
[6]"IPPS rule finalizes certain physician self-referral provisions," AHANews.com, Aug. 4, 2008, http://www.ahanews.com/ahanews_app/jsp /display.jsp?dcrpath= AHANEWS/AHANewsNowArticle /data/ann_080804 _niche&domain=AHANEWS (Accessed 8/20/08).
[7]"Stark Rule Proposals Finalized," By Cathy Dunlay and Kevin Hilvert, Schottenstein Zox & Dunn Resources, 8/13/08, http://www.szd.com/resources.php?NewsID=1184&method=unique (Accessed 8/14/08).
[8]"Stark Rule Proposals Finalized," By Cathy Dunlay and Kevin Hilvert, Schottenstein Zox & Dunn Resources, 8/13/08, http://www.szd.com/resources.php?NewsID=1184&method=unique (Accessed 8/14/08).
[9]"Stark Rule Proposals Finalized," By Cathy Dunlay and Kevin Hilvert, Schottenstein Zox & Dunn Resources, 8/13/08, http://www.szd.com/resources.php?NewsID=1184&method=unique (Accessed 8/14/08).
[10]"Stark Rule Proposals Finalized," By Cathy Dunlay and Kevin Hilvert, Schottenstein Zox & Dunn Resources, 8/13/08, http://www.szd.com/resources.php?NewsID=1184&method=unique (Accessed 8/14/08).

reduction of waste or change in physician clinical or administrative practices, without an adverse affect on or diminution in the quality of hospital patient care services."[9] Additionally, the program must:

(1) Include patient care quality or cost savings measures (or both) supported by objective, independent medical evidence indicating that the measures would not adversely affect patient care, and the measures must be listed in CMS' Specifications Manual for National Hospital Quality Measures;
(2) Employ cost savings measures which use an objective methodology, are verifiable, supported by credible medical evidence indicating that the measures would not adversely affect patient care, be individually traced and reasonably relate to the
services provided;
(3) Be reviewed prior to implementation and at least annually thereafter to ascertain the program's impact on patient quality of care, and that such reviews must be independent medical reviews conducted by a person or organization with relevant clinical expertise;
(4) Provide for immediate and corrective action (up to and including termination of the program) in the event a review reveals an adverse impact on quality;
(5) Limit participation in the program to those physicians who are members of the hospitals' medical staff at the commencement of the program, and that participating physicians participate in "pools" of five or more (formed at the commencement of the program) among whom the aggregate cost savings that result from the efforts of the physicians in the "pool" be shared on a *per capita*basis;
(6) Support the distribution of shared savings program payments with written documentation;
(7) Not determine eligibility for physician participation in the program based on the volume or value of referrals or other business generated between the physician the
hospital; and,
(8) Not limit the discretion of physicians to make medically appropriate decisions for their patients, nor limit the availability of, or access of physicians to, any specific item, supply or device that is linked through objective evidence to improved outcomes and which is clinically appropriate and which was available at the

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HCC Services - Valuation Consulting

There are many events that may set the stage for the valuation (appraisal) of a healthcare enterprise. Whatever the reason for the valuation, there are significant and complex aspects of each transaction, related to the reimbursement, regulatory, technological and competitive environment, which should be investigated and carefully considered as the basis of a successful outcome to the valuation analysis. Consulting with the HCC team of qualified, experienced and certified

[11]73 Fed. Reg. 48721 (Aug. 19, 2008).
[12]73 Fed. Reg. 48730 (Aug. 19, 2008).
[13]"CMS rescinds changes to incident-to billing rules," MGMA, http://www.mgma.com/policy/default.aspx?id=20030 (Accessed 9/3/08).
[14]"The Ins and Outs of 'Incident-to' Reimbursement," By Alice G. Gosfield, J.D., American Academy of Family Physicians, Nov/Dec 2001, http://www.aafp.org/fpm/20011100/23thei.html (Accessed 9/3/08).
[15]"CMS rescinds changes to incident-to billing rules," MGMA, http://www.mgma.com/policy/default.aspx?id=20030 (Accessed 9/3/08).

Health Net Settles Ingenix Reimbursement Rate Suit

[Full Article]

Health Net Settles for $215 in Most Recent Installment of Saga Over Ingenix's "Usual, Customary, and Reasonable" Reimbursement Calculations

On July 24, 2008, the U.S. District Court for the District of New Jersey approved a $215 million settlement between health insurer Health Net, Inc. (Health Net) and the plaintiffs in three related class actions, all of whom were members of Health Net's health care plans. The settlement resolves an action based on a complaint alleging that Health Net held their *out-of-network* reimbursements rates inappropriately low based on flawed reports of providers' charges produced by Ingenix, Inc. (Ingenix), a UnitedHealth Group subsidiary.[1] This is not the only allegation that Ingenix maintained flawed data on the *"usual, customary, and reasonable"* rates at which members of health plans are reimbursed for *out-of-network* services. Andrew Cuomo, the Attorney General for the State of New York, announced in February that he was commencing an *"industry-wide investigation"* into the *"fraudulent reimbursement scheme[s]"* of some of the nation's largest health insurance companies, including Aetna, Empire BlueCross BlueShield, and UnitedHealth Group, the parent company of Ingenix, as well as against Ingenix itself, which provides healthcare billing information to the insurers.[2] A recent class action lawsuit filed in the U.S. District Court for the District of Connecticut also alleges that Ingenix and various health insurance providers (including UnitedHealth Group, Oxford Health Plans, Aetna, Cigna and others) conspired together to *"depress reimbursements"* and *"[force] policyholders to pay 'unlawfully inflated out-of-pocket expenses."*[3]

The gravamen of the New Jersey and Connecticut class actions, as well as the New York Attorney General's investigation, is that Ingenix produces inappropriately low data on the *"usual, customary, and*

commencement of the program.

Payments made under shared savings programs:

(1) Must be distributed on a *per capita*basis;
(2) May not include any amount that takes into account the provision a greater volume of Federal health care patient procedures or services than the volume provided by the participating physician or qualified physician organization during the period of the same length immediately preceding the commencement of the program as that covered by the payment; and,
(3) Must be limited in duration (no shorter than 1 year and no longer than 3 years) and amount.

There are two potential ways to limit amount of payments, one or both of which may be adopted:

(1) Limits based on set percentages of cost savings available to hospital through program; and,
(2) Limits to address the risk that physicians will continue to receive financial rewards for already implemented changes.

Also, arrangements in which physicians receive payments for actions taken that result in a reduction below a predetermined target based on objective historical and clinical measures will not be protected.

Additionally, CMS is considering whether to extend the exception for *"qualified physician organizations"* to multi-specialty physician practices composed of both participating and non-participating physicians. To promote transparency, hospitals and participating physicians will be required to disclose the nature of the program to patients affected by it. Requirements related to transparency include:

(1) Tracking of the ages and payors of patient population treated by participating physicians (to prevent cherry picking, etc);
(2) Limiting physician payment to only that which is related to the physician's own efforts, combined with the efforts of the other physicians in their pool, on a per capita basis;
(3) Applying all measures uniformly to all patients, including Medicare beneficiaries (and not applying them disproportionately to Federal health care program beneficiaries), with the possibility of having the program audited; and,

healthcare valuation professionals will ensure a thorough analysis of the subject entity, or property interest to be appraised, within the context of the marketplace in which it exists.

HCC provides opinions of value, in both the for-profit and tax exempt arenas, for the sale or transfer, merger & acquisition, lending & capital formation, liquidation or dissolution of healthcare enterprises, as well as the valuation of intangible assets, healthcare services, executive and physician compensation packages, and intellectual property. HCC's valuation services are also provided to support expert testimony in litigation support settings, for management planning, insurance claims, gift & estate tax planning, and for other related purposes.

The scope of HCC valuation services ranges from comprehensive, formal written reports with certified opinions to limited, restricted use analyses and valuation consultations. HCC conducts each valuation engagement in accordance with the Uniform Standards of Professional Appraisal Practice (USPAP), as well as the standards and codes of ethics of the American Society of Appraisers (ASA), the Institute of Business Appraisers (IBA) and The National Association of Certified Valuation Analysts (NACVA).

HCC Services - Intermediary Services

The pace of change occurring in the healthcare industry is forcing healthcare professionals and organizations to examine the way they deliver their services and search for more efficient ways to treat patients. For many healthcare providers, consolidation, mergers, strategic alliance, and, in some cases, timely divestiture, have been viewed as key to survival.

As certified, professional business intermediaries, HCC combines a depth of experience as negotiators and intermediaries with the knowledge of required legal and regulatory issues and adherence to a time tested process to get the job done, to assist our clients, as well as their legal and accounting professional advisors, in planning and implementing a successful transition by:

- •Conducting research and a feasibility analysis specific to your market circumstances to make certain our clients will not be "All dressed up with nowhere to go!"
- •Presenting available options, and then

reasonable" (UCR) rates at which certain services are billed, which, in turn, are used by the insurance companies to determine how much to reimburse members for *out-of-network* services. Under Ingenix's reimbursement method, out-of-network services are generally reimbursed at 80% of the physician's full bill or the UCR rate, whichever is less.[4] The class action plaintiffs and the Attorney General allege that because Ingenix is a subsidiary of UnitedHealth Group, it has a *financial interest* in keeping reimbursement costs low, which has led it to *inappropriately assess the value of the UCR rate*[5] . The allegation goes on to demonstrate that the Ingenix database is *inherently flawed* because the information it disseminates to the insurance providers is based on value data provided by those insurance companies in the first place. In other words, the UCR data is *never audited* by any outside entity.[6]

The American Medical Association has repeatedly supported these actions and the investigation by Attorney General Cuomo. Dr. Ronald M. Davis, President of the AMA, declared that *"Cuomo's investigation has discovered what the AMA has been saying for years: that Ingenix operates a defective and manipulated database that some health insurers use to set reimbursement rates for out-of-network expenses."*[7] Particularly of concern to the AMA is the impact that this practice has had on physician-patient relationships, i.e., when patients receive a lower reimbursement from their insurance companies than the rate their physicians charge them, physicians get accused of overcharging. This is a situation, Dr. Davis argues, that *"can impair or destroy a patient-physician relationship."*[9] The AMA has been involved in its own class action against United and Metropolitan Life Insurance since 2000 (now still pending in the U.S. District Court for the Southern District of New York), and it believes that its own case may be helped by Cuomo's investigation, as well as by a recent decision in a Massachusetts state appellate court[9] which remanded a similar case to the trial court in favor of the chiropractor plaintiff, *holding that Ingenix's database was not an accurate representation of UCR rates*.[10]

These cases, particularly the recently settled class action in New Jersey, have significant implications for the healthcare insurance industry. While Cuomo is investigating Ingenix and the insurance companies under New York state laws, the Connecticut case

(4) Prohibiting the counseling or promotion of a business arrangement or other activity that violates any Federal or State law.[10]

During the open comment period which ended on August 29, 2008, CMS received an overwhelming amount of support for the exception from physician groups. Additional support came from the American Medical Association, which recognized the potential from gainsharing arrangements to improve health care delivery systems, but also advised CMS to be cautious due to the potential of shared savings programs to implicate fraud and abuse laws.[11] Congressman Pete Stark (D-CA) disagreed with a broad exception to the self-referral laws he authored, arguing that gainsharing programs run counter to the goals of self-referral laws because they *"create financial incentives for physicians to refer patients to particular hospitals, not necessarily because it is in the best interest of the patients, but because physicians stand to gain financially from doing so."*[12] Rep. Stark suggests that CMS should wait to make changes to the self-referral law until after the completion of three gainsharing demonstration projects which have been authorized by Congress. Whether or not CMS listens to his suggestions, however, will be revealed on November 1, 2008, when the Final Rule is set to be issued.

[1]73 Fed. Reg. 38502 (July 7, 2008).
[2]73 Fed. Reg. 23692 (April 30, 2008).
[3]73 Fed. Reg. 23692 (April 30, 2008).
[4]73 Fed. Reg. 23693 (April 30, 2008)
[5]73 Fed. Reg. 38548 (July 7, 2008).
[6]73 Fed. Reg. 38550 (July 7, 2008).
[7]73 Fed. Reg. 38550 (July 7, 2008).
[8]73 Fed. Reg. 38552 (July 7, 2008).
[9]73 Fed. Reg. 38552 (July 7, 2008).
[10]Everything from 73 Fed. Reg. 38552-58 (July 7, 2008).
[11] "Physicians Support Gainsharing Exemption; Stark Says Proposal Risks Fraud, Abuse," BNA Health Law Reporter, Sept. 11, 2008, pg 1198.
[12] "Physicians Support Gainsharing Exemption; Stark Says Proposal Risks Fraud, Abuse," BNA Health Law Reporter, Sept. 11, 2008, pg 1198.

HCC - Background

Health Capital Consultants (HCC) is a nationally recognized healthcare economic and financial consulting firm specializing in valuation consulting; financial analysis, forecasting and modeling; litigation support & expert testimony; mergers and acquisitions; certified intermediary services; provider integration, consolidation & divestiture; certificate-of-need and other regulatory consulting; and, industry research services for healthcare providers and their advisors.

facilitating a consensus decisions as to future direction;
•Assessing external strategies including outright ownership, partnership, leasing or collaborative joint venture arrangements to allow our clients to take advantage of synergistic affiliations, with consideration to the impact on their autonomy;
•Assisting in positioning our client's organization for future merger, consolidation, integrated provider relationships, or divestiture;
•Assisting, if needed, in identifying qualified prospects;
•Assisting in the negotiation and implementation phases of our client's project;
•Structuring the governance and operation of newly integrated entities to succeed; and,
•Providing consistent project management to aggressively move projects forward.

HCC Services - Financial Analysis

Health Capital Consultants (HCC) designs and develops financial models and performs financial analysis engagements that provide a comprehensive assessment, analysis, and full disclosure of your organization's financial position or the feasibility of planned ventures. The HCC analytical process may include benchmarking to industry norms, and a comparison to your specific segment of the healthcare industry and market. Our financial analysis services include:

•Financial projections, pro forma reports, and feasibility studies;
•Economic and demographic analyses and trend reports;
•Utilization demand forecasts;
•Reimbursement yield, payor mix and revenue impact reviews;
•Physician/Provider income distribution plans; and,
•Physician manpower needs surveys and community benefit analyses.

has filed its suit under *federal racketeering and antitrust laws*, as well as the Connecticut Unfair Trade Practices Act.[11] As UnitedHealth Group is one of the nation's largest health insurance providers, these cases have the potential curb the rising cost of health care and health insurance, if it is found that the insurance companies are, in fact, relying on flawed data and keeping reimbursement rates artificially low. Now that the New Jersey class action has settled, however, the courts may begin to take a more scrutinizing look at what is an appropriate means for calculating UCR rates, which has the potential to significantly improve the freedom of patients to choose their doctors without fear that they are being overcharged or under-reimbursed.

[1] "Judge approves Health Net settlement of $215 million," By Gregg Blesch, Modern Healthcare, July 24, 2008, http://www.modernhealthcare.com/apps/pbcs.dll/article?AID=/20080724/REG/977494692 (Accessed 7/28/08).
[2] "Cuomo Announces Industry-wide Investigation into Health Insurers' Fraudulent Reimbursement Scheme," Press Release, Office of the New York State Attorney General Andrew M. Cuomo, Feb. 13, 2008, http://www.oag.state.ny.us/press/2008/feb/feb13a_08.html (Accessed 7/28/08).
[3] "Health Insurers: Conspire to Cheat Patients On Reimbursement," Class Action Reporter Top Stories, May 5, 2008, http://topstories.troubledcompanyreporter.com/car/200805056.html (Accessed 7/28/08).
[4] "Investigation of health insurers is a long time coming," By Ronald M. Davis, American Medical Association, Feb. 28, 2008, http://www.ama-assn.org/ama/pub/category/print/18367.html (Accessed 7/28/08).
[5] "Notice of Proposed Litigation Pursuant to Section 63(12) of the Executive Law, Sections 349 and 350 of Article 22-A of the General Business Law, and Section 2601(a) of the Insurance Law," By Andrew M. Cuomo, Attorney General of the State of New York, Feb. 13, 2008, pg. 2-3, http://www.oag.state.ny.us/press/2008/feb/UnitedHealthcare.pdf (Accessed 7/28/08).
[6] "Notice of Proposed Litigation Pursuant to Section 63(12) of the Executive Law, Sections 349 and 350 of Article 22-A of the General Business Law, and Section 2601(a) of the Insurance Law," By Andrew M. Cuomo, Attorney General of the State of New York, Feb. 13, 2008, pg. 3, http://www.oag.state.ny.us/press/2008/feb/UnitedHealthcare.pdf (Accessed 7/28/08).
[7] "Investigation of health insurers is a long time coming," By Ronald M. Davis, American Medical Association, Feb. 28, 2008, http://www.ama-assn.org/ama/pub/category/print/18367.html (Accessed 7/28/08).
[8] "Investigation of health insurers is a long time coming," By Ronald M. Davis, American Medical Association, Feb. 28, 2008, http://www.ama-assn.org/ama/pub/category/print/18367.html (Accessed 7/28/08).
[9] Michael Davekos, P.C. v. Liberty Mutual Ins. Co., 2008 Mass.App. Div. 32, 2008 WL 241613 (Jan. 24, 2008).
[10] "Investigation of health insurers is a long time coming," By Ronald M. Davis, American Medical Association, Feb. 28, 2008, http://www.ama-assn.org/ama/pub/category/print/18367.html (Accessed 7/28/08).
[11] "Lawsuit against Ingenix seeks class-action status," By Gregg Blesch, Modern Healthcare, May 2, 2008, http://www.modernhealthcare.com/apps/pbcs.dll/article?AID=/20080502/REG/208686148 (Accessed 7/28/08).

Founded in 1993, HCC has developed significant research resources; a staff of experienced professionals with strong credentials; a dedication to the discipline of process and planning; and, an organizational commitment to quality client service as the core ingredients for the cost-effective delivery of professional consulting services. HCC has served a diverse range of healthcare industry & medical professional clients in over forty five (45) states including hospitals & health systems (both tax exempt & for profit); outpatient & ambulatory facilities; management services organizations; clinics, solo & group private practices in a full range of medical specialties, subspecialties & allied health professions; managed care organizations; biotechnology and pharmaceutical ventures; ancillary service providers; disease management firms; Federal and State agencies; public health and safety agencies; other related healthcare enterprises and agencies; and, these clients' advisory professionals, e.g., their consulting, legal and accounting firms.