CCH Health Care Compliance LETTER

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Senate approves health care reform bill; reconciliation pending

The Senate on December 24 passed its sweeping health care reform legislation, the "Patient Protection and Affordable Care Bill" (HR 3590) by a vote of 60 to 39. The vote set the stage for a contentious conference with the House to merge the two chambers' respective versions of the bill.

Calling Senate passage of the health care reform bill "a historic vote," President Obama said that Congress is "finally poised to deliver on the promise of real, meaningful health insurance reform that will bring additional security and stability to the American people." The president noted that, if a final bill is enacted, it will be "the most important piece of social policy since the Social Security Act in the 1930s, and the most important reform of our health care system since Medicare passed in the 1960s."

The bill as passed incorporated a 300-page "manager's amendment" of changes to the original bill, as well as new provisions. The manager's amendment included the adoption of the "Indian Health Care Improvement Act" (S. 1790), itself a 276-page bill. So the entire Senate bill as passed totals about 2,700 pages.

The legislation provides a sweeping overhaul of the existing health insurance market; increases insurance coverage both through the private insurance market and through an expansion of Medicaid; adjusts Medicare spending formulas for Part A providers; reduces Medicare Advantage reimbursement to a level closer to that of Medicare fee-for-service; reduced the Part D "donut hole" for prescription drug benefits; increases coverage and reduces co-payments for preventive services offered through both private and public plans; and strengthens program integrity statutes regarding both Medicare and Medicaid.

CBO analysis. The Congressional Budget Office (CBO) estimated in a December 19 report that the direct spending and revenue effects of the Senate bill would yield a net reduction in federal deficits of $132 billion over the 2010-2019 period. The CBO noted that the bill would have a projected net cost of $614 billion over 10 years for the proposed expansions in insurance coverage. This includes $871 billion in subsidies provided through the new insurance exchanges, increased net outlays for Medicaid and the Children's Health Insurance Program (CHIP), and tax credits for small employers. This new spending would be partly offset by $149 billion in revenues from the excise tax on high-premium insurance plans and $108 billion in net savings from other sources.

The number of nonelderly people who are uninsured would be reduced by about 31 million under the legislation, according to the CBO, leaving about 23 million nonelderly residents uninsured (about one-third of whom would be unauthorized immigrants). The percentage of insured residents would increase from 83 percent

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Wolters Kluwer Law & Business

to about 94 percent. Approximately 26 million people would purchase their own coverage through the new insurance exchanges, and there would be roughly 15 million more enrollees in Medicaid and CHIP than is projected under current law.

The CBO issued a third analysis of the bill on December 23rd in which it concluded that the reductions in projected Part A outlays and increases in projected HI revenues under the legislation could not simultaneously provide additional resources to pay future Medicare benefits and provide resources to pay for new programs outside of Medicare (see http://www.cbo.gov/ftpdocs/108xx/doc10868/12-23-Trust_Fund_Accounting.pdf).

Conference issues. Liberal House Democrats are unhappy that the Senate jettisoned a public insurance option. They are also opposed to language in the Senate bill that prohibits the use of federal funds to pay for abortions, a key concession necessary to win the vote of Sen. Ben Nelson (D-Neb.) The moderate lawmaker has warned that significant changes to the Senate version could cause him to vote against the final bill, leaving Senate Democratic leaders short of the necessary 60 votes required for passing the measure.

The House and the Senate also differ on how to pay for the reform package. The Senate bill raises most of the revenue for health care reform by imposing a 40-percent surtax on high-cost employer-sponsored health plans. House members from states with strong union supporters oppose the tax on so-called "Cadillac" plans and they have threatened to withhold their support of a final bill if the provision is included.

The House bill would raise revenue through a 5.4-percent surtax on high-income earners and the Senate has openly rejected that plan. Democratic aides believe, however, that both sides will eventually compromise on revenue provisions and have suggested that conferees will likely consider raising the income threshold for high-end insurance plans.

Next steps. Democratic staff members will begin laying the framework for negotiations during the week starting on December 28 and conferees are expected to return to Washington the first week of January 2010. House Speaker Nancy Pelosi (D-Calif.) has indicated that she would like to complete work on the health care reform package in time for President Obama's State of the Union address, traditionally delivered at the end of January. The White House has set no deadline for when it expects to see the final bill. ■

CCH Washington Bureau, Dec. 29, 2009

Tort reform predicted to decrease spending and increase revenues, CBO

The Congressional Budget Office (CBO) recently analyzed the budgetary effects of tort reform proposals to limit costs relating to medical malpractice. In a previous analysis, the CBO predicted that implementation of the package of tort reforms would reduce the use of health care services and, therefore, health care spending. Recently-acquired evidence further supports the hypothesis that tort reform would slightly reduce the use of health care.

Estimates of the budgetary effect of tort reform. Originally, the tort reform proposals were estimated to decrease spending by roughly $41 billion and increase revenues by roughly $14 billion from 2010 to 2019. The latest estimates are substantially larger than earlier estimates for several reasons.

First, tort reform would have a greater effect on malpractice costs than previously estimated. If the common package of tort reforms was implemented nationwide, the nation's direct costs for medical practice (consisting of malpractice insurance premiums and settlements, awards, and administrative costs not covered by insurance) would be reduced by about 10 percent. The previous estimate was about 6 percent.

Second, tort reform would result in a slight reduction to the utilization of health care services resulting from changes in providers' practice patterns. Direct savings in malpractice costs combined with indirect savings in health care services are projected to reduce national health spending by roughly 0.5 percent. The increase in the estimated effects of tort reform on health care spending (arising from both the larger estimated change in malpractice costs and the incorporation of the change in utilization owing to changes in practice patterns) implies a significant increase in the estimated effects of tort reform on both federal tax revenues and federal outlays.

Third, the effect of reduced health care spending on revenues would be greater than previously predicted. A reduction in spending would shift some compensation from employment-based health insurance

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Requests for information about article submission and comments from readers are welcome and should be directed to Susan Smith at susan.smith@wolterskluwer.com, Tel. 847-267-2780, Fax 847-267-2514. Customer service inquiries should be directed to 800-449-9525.

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Trends (cont.)

(which is excluded from income and payroll taxes) to taxable wages and salaries, thereby increasing tax revenues. A reduction in malpractice costs, a reduction in the use of health care services, and an increase in the amount of health insurance purchased (due to lower insurance prices as a result of the two other factors) are projected to reduce spending in health care. The reduction in spending due to changes in providers' practice patterns outweighs the increase in insurance purchases. Therefore, the net reduction in spending incorporating these factors is 0.5 percent.

Fourth, the reduction in utilization is projected to generate a proportionately larger reduction in federal spending on health care than in other spending in health care. Utilization of care in Medicare would be reduced more than would utilization of care as a whole. The bulk of Medicare services are provided on a fee-for-service basis, while most private health care spending occurs through plans that manage utilization of care. Accordingly, private plans may limit the use of services that have marginal benefit to patients. Moreover, the use of Medicare services is less likely to be influenced by the effects of changes in malpractice costs on premiums and cost-sharing faced by patients.

Effects of tort reform on patients' health. The CBO previously estimated that imposing limits on patients' lawsuits involving harm from negligent health care might have a negative effect on health outcomes. However, the available evidence on the subject is mixed, and the correlation between errors and malpractice claims is weaker than previously assumed. According to one study, a majority of hospital patients who were negligently injured never filed complaints; and a substantial number of filed claims involved health problems not caused by negligence.

The estimates of the likely effects of tort reform are based on research that links changes in malpractice costs to changes in health care spending. Examples of changes in spending include changes caused by providers' responses to changes in the medical liability environment, and also the spending changes resulting from associated changes in health status. Taking into consideration all of those factors, the weight of evidence indicates that tort reform would reduce the utilization of health care services and, therefore, spending. However, spending might increase for certain patients, providers, or procedures, while decreasing for others. ■

Congressional Budget Office Letter to Senator John D. Rockefeller, IV, Dec. 10, 2009

Health IT

CMS and ONC propose "meaningful use" definition and standards for EHRs

On December 30, 2009, the Center for Medicare and Medicaid Services (CMS) and the Office of the National Coordinator for Health Information Technology (ONC) issued proposed and interim final regulations, respectively, which are designed lay the foundation for the improvement of quality, efficiency, and safety in health care delivery through the meaningful use of certified electronic health record (EHR) technology. The proposed and interim final rule (IFR) will implement the EHR incentive programs enacted under the American Recovery and Reinvestment Act of 2009 (Recovery Act). The CMS proposed rule outlines provisions governing the EHR incentive programs, including defining the central concept of "meaningful use" of EHR technology. The ONC IFR sets forth initial standards, implementation specifications, and certification criteria for EHR technology.

CMS and the ONC worked in concert to draft the rules with hundreds of technical experts, health care providers, and other industry stakeholders providing input. Numerous public meetings were also held by the National Committee on Vital and Health Statistics, the Health IT Policy Committee, and the Health IT Standards Committee to obtain public comment.

Recovery Act. The Recovery Act established programs to provide incentive payments to eligible professionals and eligible hospitals participating in Medicare and Medicaid that adopt and make "meaningful use" of certified EHR technology. Incentive payments begin October 2010 for eligible hospitals and in January 2011 for other eligible providers.

Interim final rule. Under the Recovery Act, HHS was required to adopt an

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On The Front Lines

The Role of the Board in Hospital Compliance: A Checklist to Analyze Your Board's Performance-Part 2

by Seth M. Lloyd, J.D., Howard E. O'Leary, Jr., J.D., and Thomas J. McGraw, J.D.

What is the appropriate role for the governing body of a health care organization (its "board") in its attempts to comply with the wide variety of laws and regulations to which it is subject regarding the submission of claims, fraud and abuse, and Stark? In Part 1 of this two-part article, the authors began by addressing this question, setting forth four specific issues and providing a brief history of government pronouncements on compliance, including some recent pronouncements. In this Part 2, the authors suggest a practical guide to compliance, including a discussion of organizational education, compliance program structure, and evaluation of compliance within the organization.

A Board's Practical Guide to Compliance

Because most health care organizations already have a compliance plan, this article does not deal with the task of putting in place a plan where none now exists, or with the specific content of the plan. Rather, we assume that such a plan is in place and ask what the board should do now.

We begin with education.

Has your organization provided education to all board members regarding the need for a compliance program? If the board is to have oversight responsibility for the compliance operations of the organization, how can it fulfill that responsibility if it does not understand the need for a compliance program in today's environment? Education is the key. We do not mean to suggest that every board member must become an expert in health care compliance. We do mean to suggest that a periodic program on the particular need for robust compliance operations in a highly-regulated industry like health care is an absolute essential. Many board members, who come from other regulated industries, will quickly grasp the need for such activities. Some, who are community leaders but not from such industries, may find this subject a bit of a mystery. A periodic educational session for the board – and a primer for newly-elected board members – seems essential. Ask your outside counsel to present a session at a board meeting on compliance in the health care industry. Keep records of the presentations and who attended. Impose a requirement that every board member receive this instruction.

Has your organization explained to all board members the principal elements of your compliance program? Does the board understand how its plan works? We've assumed that the organization has a compliance plan. The board needs to understand what's in it and how it works. Is there an internal audit function? Is there a hotline? What happens to audits or complaints to the hotlines? Who is trained about compliance and on what subjects? In short, the board needs to understand the core elements of the organization's compliance plan.

Has your organization explained to all board members on what substantive areas the compliance program will focus in the current year, and why those were chosen? Most compliance officers place specific emphasis on topics which they know will be of interest to third parties, most particularly Medicare and Medicaid. What are the topics on which your compliance program will focus in the upcoming year, and why were they chosen?

Has your organization described for the board the resources devoted to compliance? If, as we will see below, the board is to evaluate periodically the effectiveness of the compliance program, it should know what resources – people and money – the organization devotes to such activities. Can the compliance officer reasonably accomplish the goals set for him/her with the resources available?

We turn next to an evaluation of the program's structure.

Should the board delegate to a committee responsibility for compliance and, if so, what authority should the board committee be given? Most boards of health care organizations delegate important responsibilities to board committees. Compliance is no exception. Indeed, the HHS-OIG/AHLA publication specifically recommends

the appointment of a board compliance committee.[10] A suggested Draft Resolution Delegating Compliance Responsibilities to a Committee of the Board is provided at the end of the article. We see no reason why compliance responsibilities require a separate board committee, although there certainly would be no objection to such a structure. Many organizations combine compliance responsibilities with the audit committee. If compliance responsibilities are delegated, is there any role for the board itself to play thereafter? We believe that the answer to that question is a resounding yes. The educational activities described above should still involve the board, whose fiduciary responsibilities to the organization require their education and ultimate oversight. What about the structural recommendations which follow? We will deal with the board committee versus board issue in the context of each.

Does the compliance officer have direct access to the organization's CEO, without having to obtain permission from any other official? The sources discussed above make it clear that the compliance officer should report directly to the organization's CEO. What is not clear is whether a reporting relationship that runs through an intermediary official, who himself/herself does report directly to the CEO, is sufficient. So long as the compliance officer can on his/her own motion have "direct access" (see below for a discussion of the meaning of this term) to the CEO, it would not seem to matter. The compliance officer should not report, however, to the CFO or to the chief legal officer. The HHS-OIG admonished that there is "some risk" of the compliance officer reports to the corporation's in-house lawyer.[11] The reason for this appears to be that the lawyer may have already approved something which has now been raised as a possible compliance issue. (The same would appear to be the case with the CFO.) The potential for conflict in such situations is obvious.

What should be the day-to-day relationship between these two important positions? Two things should be said. First, in all except the situation mentioned above – where the compliance "issue" is something which the lawyer has already approved – the relationship between compliance officer and in-house lawyer should be complementary. The two should work in tandem to understand the potential issue and its relationship to the pertinent law or regulation. Second, by working together in the investigation of the issue, or by soliciting the in-house counsel to find appropriate outside lawyers to investigate and advise, the corporation's investigation of a matter can be protected by the attorney-client privilege. This privilege can be important in some cases to allow the corporation to receive the advice of a trained professional and determine together how a matter should be handled without that deliberative process being open to discovery. In short, in most cases, the relationship between the compliance officer and in-house lawyer should be cooperative.

Under what circumstances can the compliance officer meet directly with the board or board compliance committee? All of the sources advocate that the compliance officer have "direct access" to the board. None of them explains what is meant by this term. Many health care organizations have board committees responsible for compliance. If such a committee exists, shouldn't the compliance officer in almost every case have the ability – indeed, shouldn't it be the expectation that he/she will meet – to meet directly with this committee on a regular basis? If this is the case, and we see no reason why it should not be, is there any circumstance in which the compliance officer could bypass the board committee and go directly to the full board? We see no persuasive reason for this.

The pertinent question becomes, then, in what circumstances should the compliance officer report directly to the board committee without first reporting to the CEO? Clearly, in any typical entity, the compliance officer should take matters first to those to whom he/she reports (assuming that it is someone other than the CEO) and, ultimately to the CEO. Can the compliance officer ever bypass the CEO and go directly to the board compliance committee (or the board, if no board committee exists, or the board committee refuses to act)? The answer to this question is yes, but only in one of two situations: (1) the alleged compliance issue is that the CEO has violated the law, or (2) the CEO, having been informed of the issue, has refused to deal with it. In situation (1), the compliance officer must take the issue directly to the compliance committee chair (or, in the absence of a committee or if the board committee refuses to act, to the board chair) and ask very difficult questions: How do you want to deal with this? Do we want to hire someone from the outside to investigate this? In situation (2), the need for the compliance officer to go directly to the committee chair seems apparent, but after saying to the CEO that his/her refusal to deal with issues will have that result. We see no other situations in which "direct access" to the board committee or board is appropriate.

What information about compliance issues faced by your organization does your board or board committee receive? This question begs the real question: what information does the board committee or board need? The committee or the board needs to know about significant compliance matters and how the corporation is addressing those risks. This does not mean, of course, that every call to the compliance program's 800 number is reported to the board. Nothing would typically be reported until an investigation, conducted by the compliance officer or counsel, revealed there to be a problem of some significance. We think it

self-evident that investigations by governmental agencies and lawsuits of significance should be reported. How else can the board committee or board be expected to know about whether the compliance program is effective in preventing compliance issues and, after they surface, resolving them successfully? If the organization has a board committee, when should the committee report such matters as are brought to it to the full board? Must those reports be made by the compliance officer, as opposed to the chair of the board committee? Regular reports would seem advisable, probably with the same frequency as reports from other significant committees. We regard it as unimportant whether the reports are made by the compliance officer himself, as opposed to the committee chair.

What are the limits, if any, on the compliance officer's ability to address problems directly on his/her own? Note the 2005 suggestion from the HHS-OIG that the compliance officer have the authority to retain separate legal counsel.[12] This suggestion squarely raises the question of the independent authority of the compliance officer. What are appropriate limits on this authority? Clearly, in most cases, the compliance officer will work through channels, and that is how it should be.

If working through channels is not working, however, we have already discussed the necessity for the compliance officer to go directly to the CEO. In turn, if the CEO is the problem, the compliance officer should have direct access, i.e., the ability to initiate a face-to-face meeting, with the board compliance committee or, in the absence of such a committee or in the face of its refusal to act, with the board itself. Having taken this significant step, should the compliance officer have any other independent authority? We can see no reason why he/she should, having raised the matter directly with board representatives. From that point, the compliance officer should act at the direction of the board committee or board, whichever has responsibility.

Finally, we look at the board's evaluation of compliance within the organization.

Has the board or board committee asked the organization's leaders how they will measure whether the compliance program is effective, and is the board satisfied with the answer? As noted above, the board or board compliance committee will receive regular reports of compliance matters. How will the board or board committee evaluate whether the compliance program is effective? In the first instance, as the HHS-OIG/AHLA publication suggests, the board or board committee should insist that the CEO or other appropriate senior official evaluate the effectiveness of the program.[13] What will be the measures of effectiveness that will be employed? Here are some suggestions. Is there a confidential hotline for employees and others to report suspected compliance matters? How many matters are being reported on the hotline? The absence of reported matters may signal a workforce that doesn't believe that reports will be taken seriously or that fears retaliation. Conversely, is an unusually high number of significant matters being reported? If so, why? The board must be concerned in such a situation about whether sufficient resources have been devoted to compliance and about whether those in charge of the program have done a sufficient job in finding and eliminating compliance issues. Are matters languishing? If so, the board must be concerned about the effectiveness of the compliance operation and the organization's leadership in dealing head-on with matters of such importance. Agreeing on the measures of effectiveness ahead of time will itself assist in the education process.

In addition, the board or board committee should be insistent on when the measurement will occur, and then engage in rigorous evaluation. And such an evaluation should be made with regularity, probably once a year, so that the budget for the upcoming period can be adjusted, for example, to allow additional resources to be brought to bear on this crucial area if its effectiveness is suspect.

Conclusion

Few areas within the operations of a health care organization present greater risk to the organization than the failure to comply with state and federal laws and regulations relating to the submission of claims, fraud and abuse, and Stark. Yet, most boards pay scant attention to the organization's best defense against this risk – the compliance program. If the board cannot answer each question posed (see checklist below) in this article appropriately, its members may not be paying sufficient attention.

A Board Checklist on Compliance:

- Have all board members received education on the need for a compliance plan?
- Does the board understand how the plan works?
- Does the board understand the plan's focus?
- Has the board formally delegated compliance responsibility to a committee?
- Does the board receive regular reports about significant compliance matters facing the organization?
- Does the compliance officer have an appropriate reporting relationship and adequate authority and resources?
- Does the board regularly evaluate the effectiveness of the compliance program?

Draft Resolution Delegating Compliance Responsibilities To A Committee Of The Board

Whereas, the Board of Directors of the Corporation has ultimate responsibility for ensuring that the Corporation operates in compliance with all state and federal laws and regulations;

Whereas, [the Board wishes to] [the Bylaws] give the _____ Committee primary responsibility for monitoring the Corporation's compliance efforts; and

Whereas, the Board desires to state clearly its desires regarding the Committee's responsibilities;

On The Front Lines (cont.)

NOW, THEREFORE, IT IS HEREBY RESOLVED as follows:

(1) The Committee shall meet as often as necessary, but not less than quarterly, with the Corporation's compliance officer for the purpose of receiving an oral and written report on the operation of the compliance program and any significant, pending compliance matter.

(2) The Committee shall meet with the compliance officer at any other time the compliance officer requests a meeting.

(3) The Committee shall report to the Board, either orally or in the form of minutes of the Committee's most recent meeting with the compliance officer, highlighting the operation of the compliance program and any significant, pending compliance issue.

(4) The Committee is directed to meet at least once each fiscal year with the Corporation's Chief Executive Officer and compliance officer, together with such other officers, agents and employees of the Corporation as desired by the Chief Executive Officer, for the purpose of establishing a methodology to measure the effectiveness of the compliance program. The Committee will report this methodology to the Board and will, at a time determined by the Committee, conduct such an evaluation. The results of this evaluation shall be reported to the Board.

(5) From time to time, the Committee shall consider whether amendments to the compliance program should be adopted in order to increase its effectiveness, and shall propose such amendments to the Board it deems necessary and appropriate.

(6) The Chair of the Committee shall have direct access at all times to the Chairman of the Board of the Corporation for the purpose of discussing any matter regarding compliance. ■

Seth M. Lloyd, J.D., is a member of the law firm Dykema's Health Care Practice Group, which he headed for many years, and the firm's Employment Practice Group. Mr. Lloyd serves as principal outside counsel to a number of Michigan hospitals and health systems. His practice focuses on health care mergers and acquisitions, governance matters, corporate reorganizations, joint ventures, exclusive contracts with hospital-based physician groups, and nonprofit tax matters.

Howard E. O'Leary, J.D., is Of Counsel in Dykema's Antitrust and Trade Regulation, Government Contracts, Litigation, Health Care and Securities Litigation practices. He is a former Assistant United States Attorney and former Chief Counsel and Staff Director of the U.S. Senate Antitrust and Monopoly Subcommittee. He represents companies and individuals in criminal, civil and administrative investigations conducted by federal and state law enforcement agencies in a variety of areas, including antitrust, defense procurement fraud, healthcare fraud, Foreign Corrupt Practices Act and Securities and Exchange Commission improper revenue recognition and insider trading matters.

Thomas J. McGraw, J.D., is the leader of Dykema's Health Care Practice Group. His practice is devoted to representation of health care facilities and practitioners in corporate and regulatory matters with emphasis on mergers, acquisitions, joint ventures and compliance matters. He has developed compliance plans for health care providers, regularly counsels clients on compliance with Stark and other fraud and abuse regulations, and has represented hospitals, clinical laboratories and other health care providers in fraud investigations conducted by federal and state enforcement agencies.

[10] Such a board committee is in addition to the organization's compliance committee, usually headed by the compliance officer and composed of individuals – either employees or independent contractors – who are not board members.

[11] 63 FR 8993 (Feb. 23, 1998), fn. 35.

[12] 70 FR 4875 (Jan. 31, 2005).

[13] Corporate Responsibility and Corporate Compliance, 2003, p. 5.

Health IT (cont.)

initial set of standards for EHR technology by December 31, 2009. The IFR issued by ONC describes the standards that must be met by certified EHR technology to exchange health care information among providers and between providers and patients. The IFR describes standard formats for clinical summaries and prescriptions; standard terms to describe clinical problems, procedures, laboratory tests, medications and allergies; and standards for the secure transportation of this information using the Internet. The IFR also asks the industry to standardize the way in which EHR information is exchanged between organizations, and provides criteria for certification of EHR technology. The IFR will go into effect 30 days after publication, with public comment requested over the next 60 days. A final rule will be issued in 2010.

Proposed rule. The proposed rule would define the term "meaningful EHR user" as an eligible professional or eligible hospital that, during the specified reporting period, demonstrates meaningful use of certified EHR technology in a form and manner consistent with certain objectives and measures presented in the regulation. These objectives would include using certified EHR technology to reduce health care disparities, improve coordination of care, improve public health, while ensuring proper privacy and security of protected health information. The proposed rule would also define "meaningful use" for the Medicare EHR incentive programs by proposing one definition that would apply to eligible professionals participating in the Medicare fee-for-service and the Medicare Advantage EHR incentive programs and a second definition that would apply to eligible hospitals and critical access hospitals. The rule would allow States to request CMS approval to implement additional meaningful use measures, but would not allow approval of less rigorous meaningful use measures than required by the rule. This rule proposes a phased approach to implementation based on currently available technological capabilities and providers' practice experience. The proposal has a 60-day comment period.

Certification of HIT. The ONC plans to issue a notice of proposed rulemaking in early 2010 requesting industry input on the certification of health information technology. ■

HHS Press Release, Dec. 30, 2009

Employment

Pay scale differential not based on gender

Current and former female nurse practitioners did not present any evidence that a decision to pay male physician assistants on a national scale and nurse practitioners on a regional scale was based on the sex of the employees. The Equal Pay Act (29 U.S.C. §206(d)(1)) prohibits employers from discriminating on the basis of sex by paying an employee at a rate less than that paid to an employee of the opposite sex.

Gender ratios. Thirty-five female nurse practitioners employed by the Department of Veteran's Affairs in the Tennessee Valley Healthcare System alleged the female nurse practitioners were paid at a lower rate than the male physician assistants, and they all performed jobs of equal skill, effort and responsibility under similar working conditions. The statistics from 2004–2008 show the percentage of female nurse practitioners ranged from 78.4 percent to 80.6 percent and female physician assistants ranged from 40 to 44 percent. The nurse practitioners, however, failed to present evidence that the pay differential between nurse practitioners and physician assistants was based on sex.

Separate pay scales. The pay differential between nurse practitioners and physician assistants was based on two separate pay scales, a regional scale for nurse practitioners and a national scale for physician assistants. Other courts have held that proof of discriminatory intent was not required to establish a prima facie case under the Equal Pay Act, but there was a fundamental difference between a showing of discriminatory intent and a showing that discrimination based on sex exists or at one time existed.

The nurse practitioners' reliance on gender ratios between the two groups did not establish discrimination based on gender. The record did not suggest that the hospital was hiring female physician assistants to avoid liability under the Equal Pay Act. Accordingly, summary judgment granted by the Court of Federal Claims was affirmed. ■

Yant v. U.S., Fed. Cir., Dec. 14, 2009, Health Care Compliance Reporter, ¶800,790

In the News

Health IT workforce grants announced

The Office of the National Coordinator for Health Information Technology (ONC) in HHS recently announced the availability of two additional grant programs to support the training and development of the skilled workforce required to support broad adoption and use of health information technology (health IT). The grants are authorized by the American Recovery and Reinvestment Act (ARRA) (PubLNo 111-5), and aim to strengthen and support the health IT workforce. The new grant programs will award $32 million to establish university-based certificate and advanced degree health IT training programs and $6 million dollars to develop a health IT competency examination program. The ONC anticipates issuing approximately eight to twelve one-time funding awards to support academic programs that increase the availability of individuals qualified to serve in specific health IT professional roles requiring university-level training. The ONC further anticipates issuing a single one-time funding award to support the development and initial administration of a set of health IT competency examinations.

CCH Chicago Bureau, Dec. 23, 2009

Pharmacy supplier and HHS settle for $98 million

A supplier of pharmacy services recently agreed to pay $98 million to HHS and several state Medicaid agencies to settle three whistleblower suits that uncovered an alleged multifaceted kickback scheme. The supplier concentrated its business in the provision of pharmacy services to long-term care facilities. It allegedly paid $50 million to two nursing facility chains in exchange for 15-year contracts for referral of their patients' prescription drug purchases, including prescriptions covered by Medicare and Medicaid. In addition, the company, among other things, allegedly: violated the anti-kickback law by providing consulting pharmacy services to nursing homes at rates that were below both the fair market value of the services and its cost to furnish them in exchange for the homes' purchase of the drugs and dispensing pharmacist services; solicited and received $8 million from a drug maker to induce it to purchase generic drugs and to recommend that its physicians prescribe the drugs for their patients; and received quarterly rebate payments from the manufacturer of an antipsychotic medication in exchange for an "active intervention" program.

U.S. ex rel. Maguire v. Omnicare, Inc., D. Mass., Dec. 4, 2009, Health Care Compliance Reporter, ¶800,789

Cardiologists sue HHS Secretary over payment rates

The American College of Cardiology (ACC) filed a complaint against HHS Secretary Sebelius alleging that Sebelius, in her capacity as HHS Secretary, unlawfully adopted the payment rates for cardiology services in the 2010 Medicare Physician Fee Schedule (PFS) by using the Physician Practice Information Survey (PPIS), despite the presence of clear defects in the PPIS data, and therefore violated the Medicare statute and the Administrative Procedures Act. According to the complaint, even though the methodology and data used to develop the PPIS was defective, the PPIS was nonetheless used to justify the cuts to Medicare reimbursement rates for cardiology. ACC seeks to enjoin the implementation of the PFS for cardiologists and cardiology services based on the allegedly flawed survey data, and to require CMS to use more reliable, available data, or conduct a new survey to determine a new 2010 PFS for cardiology services performed consistent with the law.

CCH Chicago Bureau, Dec. 29, 2009