

Health Care Compliance LETTER

Volume 11, Issue 2

health.cch.com

January 22, 2008

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How to comply with the EEOC's 2007 guidelines for health care workers under the ADA

by **William P. Schurgin, Esq., Editorial Advisory Board Member** and **Annette Tyman, Esq., Contributing Editor**

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CMS proposes Secretarial review of DAB decisions

CMS has proposed to amend the Departmental Appeals Board (DAB) hearing and appeals procedures to ensure that the DAB's final administrative decisions reflect the considered opinion of the Secretary of HHS. CMS' intent is to provide sufficient safeguards to avoid placing the DAB in a situation in which it is prompted to substitute its judgment on interpretive issues for that of the Secretary.

Published guidance. In cases heard by the DAB under 45 C.F.R. Part 16 (grant disputes), the DAB would be required to follow "published guidance" issued by the Secretary to the extent it is not inconsistent with applicable statutes and regulations. By published guidance, CMS means to include guidance that has been publicly disseminated, for example, guidance issued through manual provisions, state Medicaid directors letters, or posting on the CMS website. With respect to issues of first impression when published guidance is unavailable or ambiguous, CMS has indicated that it expects the DAB to review relevant unpublished issuances in formulating its decisions. CMS has made similar proposals for conforming amendments to hearing and appeals procedures under 45 C.F.R. Part 160, Subpart E (civil monetary penalties for violations of the administrative simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (PubLNo 104-191)) and 42 C.F.R. Parts 498 and 1005 (initial Medicare determinations, sanctions on providers, enforcement remedies on laboratories).

Review authority. Under CMS' proposal, DAB decisions also would be subject to Secretarial review, including remand authority where appropriate. The Secretary would be permitted to review DAB decisions to correct errors in the application of law or deviations from published guidance. Currently, the decisions of the DAB under these various processes are considered the final agency action on matters, though they are not subject to Secretarial review.

A provision for Secretarial review of DAB decisions originally appeared in proposed DAB grant review regulations in 1981, but was omitted from the final regulations. CMS has indicated that it is again ready to propose the idea of Secretarial review to achieve consistency in decision making and ensure that the Secretary's policies are implemented correctly. The Secretary's views will continue to be subject to federal court review. Comments on the proposed rule must be received by January 28, 2008, for consideration. ■

Proposed rule, 72 FR 73708, Dec. 28, 2007, Health Care Compliance Reporter ¶730,031.

OIG approves imaging center, cost sharing, free test interpretation arrangements

In recent advisory opinions, the Office of Inspector General (OIG) explained its position on the following arrangements: (1) a physician's proposed arrangement to open a medical imaging center in the same building as his medical practice in a hurricane devastated area of Louisiana; (2) a charitable organization's existing arrangement to subsidize cost-sharing, as well as its proposed arrangement to subsidize premium obligations, owed by financially needy Medicare or Medicaid patients; and (3) an arrangement whereby a radiology group practice prepares a written report of its interpretations of radiology tests for a critical access hospital without charge to the hospital.

Medical imaging center in underserved area. A proposed arrangement whereby a physician in an underserved area devastated by Hurricane Katrina would open up a medical imaging center in the same building as his medical practice and share a 50 percent ownership interest in the center, along with his brother who would serve as the center's business manager, would not lead to the imposition of administrative sanctions or civil monetary penalties under the federal anti-kickback statute. A physician practicing in a Parish of Louisiana proposed to open up an imaging center in the same building that housed his medical practice. The population of the Parish in which the practice was located was well below 50 percent of its pre-Katrina rate and the sole Parish hospital had not reopened since the hurricane, leaving residents with no options for medical imaging services other than to leave the Parish. In addition, the number of physicians serving the area was only one-sixth its pre-Katrina level. The physician certified that his brother would be paid a salary that would be fair market value for actual and necessary services rendered and would not take into account the volume or value of business generated for the imaging center. Although potentially

applicable, the safe harbor for investment in small entities in underserved areas (42 C.F.R. §1001.952(a)(3)) is not satisfied by the proposed arrangement. One condition of the aforementioned safe harbor is that no more than 50 percent of the investment interests in an entity may be held by investors who are in a position to make or influence referrals to, furnish items or services to, or otherwise generate business for, the entity. Under the proposed arrangement, 100 percent of the imaging center would be owned by such individuals. Despite not complying with the safe harbor, the OIG does not believe that the fact that 50 percent of the imaging center will be owned by the physician's brother is a factor that will materially increase the risk of fraud or abuse. This is particularly true, according to the OIG, when viewed in light of the substantial community benefit that will be derived from the arrangement. The physician's brother is not currently in the health care business, will not be compensated in a manner that depends on his generating business for the center, and will receive a fair market value salary for services performed. He also will put up real capital and receive returns that are proportional to his capital contributions.

OIG Advisory Opinion No. 07-20, Dec. 27, 2007, Health Care Compliance Reporter ¶500,177.

Patient cost-sharing and premium subsidies. A nonprofit charitable organization's existing arrangement to subsidize cost-sharing, as well as its proposed arrangement to subsidize premium obligations, owed by financially needy Medicare or Medicaid patients with certain chronic diseases would not constitute grounds for the imposition of civil monetary penalties under §1128A(a)(5) of the Social Security Act or administrative sanctions under §1128(b)(7) or §1128A(a)(7) of the Act. The organization provides financial support to patients with certain medical conditions who have insurance coverage but cannot afford the costs

associated with the coverage. The organization operates several individual charitable funds for patients with certain serious diseases and, through those funds, provides financial assistance for specific, documented out-of-pocket expenses associated with outpatient prescription drug treatment, including cost-sharing amounts, under the

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Designer
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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.

CCH Health Care Compliance Letter is published 24 times a year by CCH, a Wolters Kluwer business, 4025 W. Peterson Avenue, Chicago, IL, 60646. Subscription rate is \$305 per year. First-class postage paid at Chicago, Illinois, and at additional mailing offices. POSTMASTER: SEND ADDRESS CHANGES TO CCH Health Care Compliance Letter, 4025 W. PETERSON AVENUE, CHICAGO, IL 60646. Printed in U.S.A. ©2008 CCH. All rights reserved.

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existing arrangement. The organization would provide comparable assistance with premium obligations under the proposed arrangement. Donor contributions to the organization could not reasonably be construed as payments to beneficiaries using the donors' products or to the organization to arrange for referrals.

The organization's subsidy of cost-sharing obligations, insurance premiums, or both for certain eligible, financially needy Medicare and Medicaid beneficiaries is not and would not be likely to influence improperly any beneficiary's selection of a particular provider, practitioner, supplier, or product because: (1) the organization assists all eligible, financially needy applicants on a first-come, first-served basis, to the extent funding is available; (2) the applicant is under the care of a physician with a treatment regimen in place at the time of application; (3) the organization makes no referrals or recommendations regarding specific providers, practitioners, suppliers, products, or plans; (4) the applicant is not informed of the identity of the donors; (5) the organization's determination of an applicant's qualification for assistance is based solely on his or her financial need, without considering the identity of his or her health care providers, practitioners, suppliers, products, or plans, the identity of any referring party, or the identity of any donor that may have contributed for the support of the applicant's condition; (6) the organization's subsidies for the patient populations it serves expands, rather than limits, patient freedom of choice; and (7) the organization's own interest as a charitable, tax-exempt entity provides a significant incentive for the organization to monitor utilization and keep subsidies to a minimum.

OIG Advisory Opinion No.07-18, Dec. 19, 2007, Health Care Compliance Reporter ¶500,175.

Radiology test interpretations. An arrangement whereby a radiology group practice prepares a written report of its interpretations

of radiology tests for a critical access hospital without charge to the hospital would not constitute grounds for the imposition of administrative sanctions under §1128(b)(7) or §1128A(a)(7) of the Social Security Act. The radiology group performs radiology services on an exclusive basis on behalf of the hospital. The hospital, via teleradiology, transmits digitized images of hospital patients to the radiology group, which then prepares a written report documenting the physician's interpretation and bills third-party payors for the services rendered by the group's physicians. Under the arrangement with the hospital, the radiology group prepares written reports of its interpretations for inclusion in the patient's medical record maintained at the hospital without charge to the hospital. Based on the Medicare payment rules, the written reports provided by the radiology group to the hospital do not constitute remuneration. The radiology group's preparation of the reports at its own cost is proper because: (1) preparation of the written reports for radiology services is part of the covered professional service that is reimbursed to the radiologist under Part B, and the radiologist is obligated to prepare the

report to receive Medicare reimbursement; and (2) by preparing the written reports, the radiology group is not relieving the hospital of any financial cost it otherwise would be obligated to incur for Medicare patients. With respect to preparing free written reports for non-Medicare patients, the arrangement poses a low risk under the anti-kickback statute because: (1) the hospital's exclusive relationship with the radiology group is at fair market value in an arms-length transaction; (2) the radiology group's preparation of the written reports without charge to the hospital appears to be a reasonable and limited service that directly relates to the professional radiology services provided by the group under its exclusive relationship with the hospital; and (3) the arrangement is unlikely to result in overutilization of federally payable services or increased costs to federal health care programs because by nature of its hospital-based specialty, the group cannot generate additional Part B billings to recoup the costs it incurs for the written reports for non-Medicare beneficiaries provided to the hospital.■

OIG Advisory Opinion No. 07-19, Dec. 21, 2007, Health Care Compliance Reporter ¶500,176.

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How to comply with the EEOC's 2007 guidelines for health care workers under the ADA

by William P. Schurgin, Esq., Editorial Advisory Board Member
and Annette Tyman, Esq., Contributing Editor

Today, approximately 20 percent of all employment discrimination charges filed with the Equal Employment Opportunity Commission (EEOC) arise under the Americans with Disabilities Act (ADA). On February 27, 2007, the EEOC issued a Fact Sheet discussing the application of the ADA to the health care industry (EEOC Fact Sheet).¹ The guidance applies to all public and private hospitals, nursing and residential care facilities, offices of physicians, dentists, and other health care providers, home health agencies, outpatient care clinics and other ambulatory care providers, and medical and diagnostic laboratories.

In issuing guidelines directed specifically to health care employers, the EEOC observed that health care is the largest industry in the American economy and has a high incidence of occupational injury and illness. The EEOC went on to state that health care workers often are exposed to airborne and blood borne infectious diseases, sharp injuries, latex allergies and other dangers. According to the EEOC, health care workers also face unique challenges because of societal misperceptions that “qualified health care providers must themselves be free from any physical and mental impairment.”

Recognizing the unique situations that arise in the health care setting, the EEOC sought to provide guidance on various topics, including:

- how the ADA defines “an employee;”
- who is “an individual with a disability” under the ADA;
- how to determine who is a “qualified person with a disability;”
- what reasonable accommodations a health care worker may require and what are the limits of an employer’s obligation to provide requested accommodations;
- under what circumstances an employer is permitted to make inquiries about an employee or applicant’s medical conditions; and
- how health care employers should address safety concerns.

Employee or independent contractor?

The ADA’s protections apply to employees and applicants for employment, but do not apply to independent contractors. In reviewing this distinction, the EEOC Fact Sheet makes the point that while many workers in the health care industry are referred to as independent contractors because they are placed through

temporary or staffing agencies, these workers may be considered “employees” of the health care provider for purposes of the ADA. As such, health care providers must review their agency relationships carefully to determine whether they may be considered the employer or joint employer of temporary workers provided by a temporary agency or staffing firm for purposes of determining potential ADA exposure. In reviewing these relationships, health care providers should look not only at their agency agreements, but also at the nature of the relationship between the health care provider and the temporary worker.

When is a health care worker an “individual with a disability” under the ADA?

A health care worker is an individual with a disability under the ADA when he or she:

- has a physical or mental impairment that substantially limits one or more major life activities;
- has a *record* of having a substantially limiting impairment; or
- is *regarded as* having a substantially limiting impairment.

Pursuant to the EEOC’s guidelines, major life activities are “basic activities that the average person can perform with little or no difficulty, such as walking, sitting, standing, lifting, reaching, seeing, hearing, speaking, breathing, eating, sleeping, performing manual tasks, caring for oneself, learning, thinking, concentrating, interacting with others, and working.”

The EEOC Fact Sheet discusses a number of factual scenarios relevant to health care workers including:

- A social worker who was diagnosed with multiple sclerosis that caused chronic, intermittent weakness and sporadic flare ups must use a wheelchair for several months. Under this scenario, the EEOC advises that the employee is “substantially limited”

in major life activities of walking and standing and, therefore, is an “individual with a disability” under the ADA.

- An applicant, who was not able to work for a two-year period due to complications from AIDS, discloses his history on a post-offer medical history form. With new medications, however, the candidate currently is able to work and has been doing so for the past five years. Under this scenario, the applicant “has a record of” a substantially limiting impairment in the past that limited him from working in a class of jobs or a broad range of jobs in various classes and, therefore, is an “individual with a disability.”
- An employee, who has a fractured vertebra, has a restriction of no lifting for six weeks, but will have no further lifting restrictions. The EEOC Fact Sheet concludes that the health care worker is not an “individual with a disability” because of the short-term nature of the lifting restriction.

It should be noted that Congress currently is considering the “ADA Restoration Act of 2007,”² which would dramatically change the ADA’s definition of a person with a disability. Under this proposed legislation, as currently worded, a disability would be defined simply as any “physical or mental impairment” without regard to whether it limits a life activity. If enacted, this legislation would expand the definition of disability to cover almost any medical or mental condition no matter how minor or short lived.

How do you determine whether a person with a disability is qualified to perform a job?

To be a “qualified” individual under the ADA, an individual must be able to perform the essential functions of the position held or desired with or without a reasonable accommodation. The essential functions of a position are those job functions that an employee must be able to perform based on factors such as:

- (1) the reason the position exists;
- (2) the number of employees available to perform the function; and
- (3) the degree or expertise required to perform the function.

Though not conclusive proof, the EEOC indicates that it will consider the employer’s judgment and a job description written before advertising or interviewing for a job as evidence of an essential function of a job. Accordingly, prudent health care providers should regularly review their job descriptions to ensure that they accurately describe the essential functions of the job.

In one of the more troubling examples contained in the guidance, the EEOC notes that *lifting* may not be an “essential” function of a registered nurse’s position, even if the requirement is set forth in the job description. The EEOC states, for instance, that if the registered nurse only spends minutes of every day repositioning or transferring patients and is “nearly always” assisted

by another person, lifting would not be an essential function of the position, regardless of how the job description is defined.

In another example, however, the EEOC finds that a pharmacy technician whose job requires him or her to spend one hour a day delivering medications to patients, but who is not able to do so (even with an accommodation) because of the mobility impairment, is not qualified to perform the job. According to the EEOC Fact Sheet, the delivery of medications to patients is an essential function of the pharmacy and the pharmacy technician is in the best position to perform that function. Therefore, the delivery function is essential even though it only takes a comparatively small amount of time each day to perform the task.

What constitutes a reasonable accommodation?

The EEOC defines a reasonable accommodation as “any change or adjustment to a job or work environment that permits a qualified applicant or employee with a disability to participate in the job application process, perform the essential functions of a job, or enjoy benefits and privileges of employment equal to those enjoyed by employees without disabilities.” In this context, the EEOC Fact Sheet advises that there are several important issues to consider including:

- An employer is not required to be clairvoyant and normally does not have to provide a reasonable accommodation unless an employee asks for one (except when the need for the accommodation is obvious).
- Once an employee asks for a reasonable accommodation, the employer should engage in an interactive process with the employee to determine what is needed and why.
- A health care provider may not rely on its own experience and knowledge as a medical professional in making the decision to grant or deny a requested accommodation.
- If an employer rejects an employee’s requested accommodation for a legitimate reason, the employer *must* offer an alternative reasonable accommodation, if one exists.
- If more than one reasonable accommodation exists, the employer may choose the least costly or difficult to provide option, as long as the accommodation is effective.
- Light duty programs do not always satisfy the reasonable accommodation requirements.

The EEOC Fact Sheet also reiterates the requirement that absent an undue hardship, employers are required to reasonably accommodate disabled employees such that they would be able to perform their essential job functions. Employers are not required, however, to accommodate an employee by removing essential functions from a position.

In applying these overriding principles to the health care industry, the EEOC Fact Sheet provides a number of factual scenarios including the following:

- A stock clerk with back and neck impairments that substantially limit him in the major life activities of reaching and lifting submits medical documentation seeking to be relieved of his newly assigned linen delivery duties because they are aggravating his back and neck conditions. The hospital denies the request because linen work is an essential function of the clerk's position and does not offer the employee an alternative. According to the EEOC's interpretation, the employer has violated the ADA because it has failed to consider other accommodations such as providing a different kind of cart or reassigning the clerk to a vacant position.
- As in other professions, health care employers may be required to make changes to their workplace facilities. For instance, if a radiology technician begins experiencing an exacerbation of asthma while performing her job duties, the employer may be required to retain an industrial hygienist to evaluate the darkroom and conduct airflow testing, and implement reasonable recommendations like installing a vent or providing a respirator mask for the employee to wear while in the darkroom.
- Changing an employee's work schedule, (e.g., excusing an individual from a shift rotation or permitting a flexible schedule rather than a set arrival time) also may be an appropriate job accommodation. For instance, it may be an appropriate accommodation to grant a fixed schedule to a nurse who submits medical documentation requesting an exemption from the shift rotation schedule because she needs to remain on a regular sleep schedule (even on weekends and vacations) due to her condition.
- Employees who suffer on-the-job injuries and file workers' compensation claims also may be covered by the ADA. For example, an emergency medical technician who injures his or her back on the job and requests reassignment to a vacant position for which he is qualified should be offered that position as an accommodation under the ADA even if the employee currently is on a workers' compensation light duty program.

Recognizing the legitimate concerns of health care providers over the spread of infectious disease, the EEOC affirmatively states that an employer may follow the recommendations of the Centers for Disease Control and Prevention Guidelines with respect to testing current employees for tuberculosis in those settings where a threshold level of risk is indicated pursuant to Centers for Disease Control Risk Assessment Standards. Similarly, the guidelines note that an employer may test applicants for employment or employees for current use of illegal drugs. Moreover, if following a leave of absence for treatment of a drug addiction, an employee is medically cleared to return to work provided he or she remain drug free, the employer may — for a reasonable period of time — require periodic drug testing.

Follow-up testing for alcohol abuse is somewhat different, as alcohol use is not excluded from coverage under the ADA like illegal use of drugs. Nonetheless, according to the EEOC Fact Sheet, an employer can undertake alcohol testing as part of a post-offer medical examination to conditionally accepted applicants for employment so long as it is done in a uniform matter. Once

employment begins, however, alcohol testing generally may be required only when the employer has a reasonable belief, based on objective evidence, that an employee has been drinking on the job, is under the influence of alcohol, otherwise may be unable to perform the essential functions of his or her job, or poses a direct threat to safety based on alcohol use.

A health care provider, like any other employer, is not required, however, to provide an accommodation that would result in an undue hardship on an employer's operations. Undue hardship means that the requested accommodation would require significant difficulty or expense. Such a defense is evaluated based upon the cost of the requested accommodation, the employer's size and financial resources, and the nature and structure of its operations. In addition, third-party funding sources also are taken into consideration for purposes of evaluating an employer's refusal to provide a requested accommodation on the grounds that it would be an undue hardship.

How do health care providers address patient safety concerns?

The EEOC Fact Sheet recognizes the unique safety questions and concerns prevalent in the health care industry, such as those involving exposure prone invasive procedures, exposure to bodily fluids, and caring for immune-compromised patients. In addition, health care employers have dual duties to protect the health and safety of their patients and their employees. Given these considerations, the EEOC understands that safety related issues may be of particular concern to employers in the health care industry.

Under the ADA, an employer may exclude an applicant or employee with a disability from a particular position, if that individual would pose a direct threat to the health or safety of others. "Direct threat" is defined as a significant risk of substantial harm ... that cannot be reduced or eliminated through a reasonable accommodation.³ Safety assessment determinations should be made based upon:

- the duration of the risk;
- the nature and severity of the potential harm;
- the likelihood that the potential harm will occur; and
- the imminence of the potential harm.

The EEOC Fact Sheet stresses that the determination of whether an employee's disability presents a direct threat to safety must be made based upon an individualized assessment of the employee's present ability to safely perform the essential functions of the job. Health care employers in particular are cautioned against using their own judgment or making categorical assumptions about what employees with a particular disability are capable of doing.

Conclusion

The EEOC Fact Sheet is a helpful tool for health care employers who are confronted with ADA issues in the workplace. The

guidelines, however, do not have the force of law and the examples provided should not be considered as definitive conclusions for assessing the appropriate application of the ADA to a particular scenario. Instead, the EEOC Fact Sheet should be viewed as a starting point for any such analysis. In this regard, it is important to recognize that the EEOC's guidance in other areas have often not been adopted by the courts. Accordingly, health care employers addressing issues raised within the EEOC Fact Sheet also should review relevant court decisions under the ADA as well as applicable state and local laws that may provide broader disability rights than those established under the ADA.

With these caveats, the EEOC's February 2007 Fact Sheet provides valuable information for health care employers addressing disability related issues within their work forces. Moreover, the EEOC's focus on the health care workers underscores the significance that the EEOC places on ADA compliance within the health care industry. Indeed, the EEOC's focus on the health care industry should be taken as a sign of the increasing scrutiny that will likely be directed toward health care employers in the application and enforcement of the ADA by the EEOC in the workplace.

Reprinted with permission from Seyfarth Shaw LLP. *William Schurgin, Esq., a partner at Seyfarth Shaw LLP, is engaged in broad-based labor and employment law, including issues arising under federal labor laws, disability discrimination laws, employment discrimination laws, collective bargaining, union representation, labor disputes, corporate campaigns, independent contractor issues, and wage and hour laws. He is an adjunct faculty member at DePaul University College of Law and Loyola University College of Law and is a member of the Editorial Advisory Board of the CCH Healthcare Compliance Portfolio and the Midwest Center on the Law and the Deaf. In addition, Mr. Schurgin is a fellow of the College of Labor and Employment Lawyers and has been selected as a member of the Leading Lawyers Network and the Illinois Super Lawyers. Annette Tyman, Esq., is an associate with Seyfarth Shaw LLP, representing management in the area of labor and employment law. She has experience litigating matters under various federal and state statutes, including Title VII of the Civil Rights Act of 1964, the Age Discrimination in Employment Act, the Americans with Disabilities Act, the Family Medical Leave Act, and numerous related state laws. Ms. Tyman also represents management in the area of labor relations, including proceedings before the American Arbitration Association.*

¹ Available at http://www.eeoc.gov/facts/health_care_workers.html.

² S. 1881, 109th Cong.(2007) and H.R. 3195, 109th Cong. (2007).

³ 42 U.S.C. §12182(b)(3).

Medicare

Part D spurs Medicare spending, cuts Medicaid spending

Medicare spending increased 18.7 percent in 2006, while annual Medicaid spending declined that year for the first time in the program's history, according to CMS. This change in spending patterns is directly attributable to the Part D prescription drug benefit. Under the benefit, drug coverage for beneficiaries who are eligible for both Medicare and Medicaid (dual eligibles) shifted from Medicaid to Medicare. In addition, continued cost containment measures by states and slower Medicaid enrollment growth spurred on by more restrictive eligibility criteria and a stronger economy also contributed to a decline in 2006 Medicaid spending growth.

Total spending. Total health care spending increased 6.7 percent in 2006. The 6.7 percent increase is only slightly higher than the 2005 increase of 6.5 percent which was the lowest

rate of growth since 1999. The 6.7 percent increase still outpaced overall economic growth, however, and was more than twice as high as the rate of inflation for 2006 (3.1 percent). Health care spending totalled \$2.1 trillion in 2006, accounting for approximately 16 percent of the nation's gross domestic product and equalling approximately \$7,026 in spending per person.

Spending breakdown. The breakdown in spending among different sectors remained the same in 2006 as in 2005. Federal, state, and local governments accounted for 40 percent of all spending; individual household spending, 31 percent; businesses, 25 percent; and other private sponsors, 3 percent. Medicare's share of federal spending increased from 29 percent in 2005 to 34 percent in 2006, while Medicaid's share decreased from 45 percent to 40 percent. The cost to households for Medicare spending increased due to the new premiums for Part D coverage.

The drug benefit also led to a slow down in the increase of out-of-pocket

spending for health care. Out-of-pocket spending grew 3.8 percent in 2006, down from a 5.2 percent increase in 2005.

Spending growth for hospital services, physician and clinical services, and nursing home and home health services all declined in 2006, compared with spending increases in 2005. CMS attributed this slowing in health care spending in part to declining inpatient hospital admissions and a reaction to a near freeze on Medicare payments to physicians.

Drug spending. Prescription drug spending increased from 5.8 percent in 2005 to 8.5 percent in 2006, well below the annual average rate of growth of 13.4 percent for prescription drugs. The 2006 rate growth was due largely to an increased use of prescription drugs as a result of Medicare Part D, new indications for existing drugs, growth in therapeutic classes, and increased use of specialty drugs. A higher generic dispensing rate helped to slow the rate of increase, according to CMS. ■

CMS Press Release, Jan. 8, 2008.

CMS improves oversight of DMEPOS suppliers

Seventy new areas across the nation will be part of the second phase of a competitive bidding program designed to lower Medicare beneficiaries' out-of-pocket costs and improve their access to certain high quality durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS). CMS recently added these new areas to the ten that currently participate in the program.

Under the program, payment amounts for certain DMEPOS, including power wheelchairs, walkers, oxygen supplies and equipment, hospital beds, and certain devices, are determined through competitive bidding. Suppliers that want to offer certain items and services to Medicare beneficiaries will have to submit bids to CMS indicating the prices at which they are willing to supply these items and services to beneficiaries. Payments are based on the bids submitted by competing contractors, and CMS determines a single payment amount for each item or service in each competitive bidding area.

Once the program is fully implemented nationally, CMS expects that it will save beneficiaries and Medicare \$1 billion annually. CMS believes that prices under the competitive bidding program will be closer to the true current market prices for DMEPOS than the prices under the existing fee schedule, which are based on the average payments Medicare has made for DMEPOS items in the past. When the total cost of the DMEPOS items and services decreases, CMS added, beneficiaries' coinsurance obligation also decreases.

The expanded competitive bidding program also is expected to help protect the Medicare program and its beneficiaries from the fraudulent business practices of DMEPOS suppliers. "Since all successful bidders will be required to meet quality standards and be accredited by Medicare, people with Medicare in these 70 new areas can be assured of access, low prices, and high quality," CMS Acting Administrator Kerry Weems said. "Through this accreditation process, [Medicare] beneficiaries are also provided another layer of protection from fraud." ■

CMS Press Release, Jan. 8, 2008.

In the News

HHA to pay \$4.7 million for self-referral scheme

A home health care agency and its owner were ordered by a federal district court to pay \$4.7 million in damages and penalties after being convicted of defrauding the Medicare program through a self-referral scheme. The owner of Aging Care Home Health of Monroe, Louisiana, submitted 615 fraudulent claims for payment to Medicare between 1999 and 2003, and repeatedly lied to federal investigators and falsified documents in an effort to cover up the fraud. The fraudulent claims were related to illegal payments the owner made to physicians who referred patients to her company. A former Aging Care Home Health employee who witnessed the fraud filed the initial complaint on behalf of the United States under the False Claims Act.

U.S. Attorney's Office for the Western District of Louisiana Press Release, Jan. 8, 2008.

Drug fraud leads to possible 30 year sentence

A jury in Miami, Florida, convicted the owner of a health care company on five counts of health care fraud, a conviction that could result in a sentence of up to 30 years in prison. The owner of Rapid Fast Health, Inc., was convicted of conspiracy to defraud HHS and submit false claims, conspiracy to commit health care fraud, and three counts of paying kickbacks. A physician at the trial testified that the owner paid her cash kickbacks to write fraudulent prescriptions for "compounded" aerosol medications and other durable medical equipment. Two pharmacy owners also testified that the owner delivered false prescriptions to them to be compounded for purposes of defrauding Medicare. One patient involved in the scheme testified that she was recruited by the owner for \$100 per month to provide her Medicare card and that the owner would drive her to visit participating physicians who would then sell her phony prescriptions. The case was prosecuted by the U.S. Attorney's Office for the Southern District of Florida with the cooperation of the Medicare Fraud Strike Force.

FBI Miami Field Division Press Release, Dec. 20, 2007.

NY insurer adopts AG's doctor ranking code

Independent Health Association, Inc., a Buffalo, New York-based insurance company, has become the latest insurer to adopt New York Attorney General Andrew M. Cuomo's "Doctor Ranking Model Code." The model code was designed to provide transparency to consumers as to how insurers rank their member physicians. The model code also requires participating insurers to retain an individual, known as a ratings examiner, to oversee compliance with all aspects of the agreement and report twice a year to the attorney general. Independent Health Association is now the seventh regional, state, or local insurer to have adopted the model code, which the New York legislature has announced plans to codify. CIGNA Healthcare agreed to adopt the code in October 2007. *See also* "CIGNA agreement focuses on oversight, transparency in doctor ranking program," Health Care Compliance Letter, Vol. 10 Issue 23, Nov. 13, 2007.

New York Attorney General Press Release, Dec. 12, 2007.