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Practitioners Discuss IRS Focus on Exempt Organizations, Provide Solutions

by Larry Perlman, CPA, J.D., LLM, Contributing Editor

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Deficit Reduction Act strengthens state anti-fraud initiatives

Gené Stephens, J.D., Contributing Editor

New provisions to combat fraud, waste, and abuse under the Medicaid program are included in the Deficit Reduction Act (DRA) of 2005, which President Bush signed on February 8, 2006.

The DRA encourages states to participate in Medicaid Integrity activities by offering point reductions in the federal medical assistance percentage (FMAP) for states whose false claims legislation meets the requirements of the Inspector General of HHS (IG). The new provisions, which become effective July 1, 2006, equip states with broader tools and incentives to combat the submission of false claims and further strengthens the federal False Claims Act (FCA).

State FCAs and reduced FMAPs. In January 2007, the FMAP will be reduced by 10 percentage points for recoveries under state false claim actions. The purpose of the reduction is to establish and maintain laws and standards for the prosecution of false or fraudulent Medicaid claims.

Generally, states must repay the federal share of any provider overpayment within 60 days of discovering it, whether or not the state has recovered the overpayment. The amount of repayment is determined by the FMAP. States whose false claim legislation meets the requirements of the IG are eligible to receive the lower FMAP. To receive the FMAP reduction, the IG, in consultation with the U.S. Attorney General, requires that the state legislation:

(1) establish liability to the state for false or fraudulent claims as described in the FCA;
(2) contain provisions that are at least as effective in rewarding and facilitating *qui tam* actions as those in the FCA;
(3) contain a requirement for filing an action under seal for 60 days with review by the state's attorney general;
(4) contain a civil penalty not less than the amount authorized by the FCA; and
(5) contain provisions that are designed to prevent a windfall recovery for *qui tam* relators that file a federal and state action for the same fraudulent claim.

Employee education. To ensure that employees receive education on the provisions of the FCA, states that receive annual Medicaid payments of at least $5 million must meet certain conditions to receive payment. Specifically, states must ensure that an employer or entity within the state:

(1) establishes written policies, procedures, and protocols for the training of all employees, contractors, or agents of the entity on the FCA, as well any administrative remedies, civil and criminal penalties, and whistle-blower protections;

(2) includes detailed provisions and training regarding the entity's policies and procedures for detecting and preventing fraud, waste, and abuse; and
(3) includes a specific discussion of such laws in any employee handbook, as well as a discussion of the whistleblower protections and the internal employer policies for detecting and preventing fraud, waste, and abuse.

Prohibition on restocking and double billing. Reimbursement of federal matching payments to pharmacies for the ingredient cost of an outpatient drug covered under Medicaid for which the pharmacy has received payment is prohibited under the DRA.

Medicaid integrity. The HHS Secretary will establish a Medicaid Integrity Program similar to the Medicare Integrity Program that will allow eligible entities to contract with the government to perform:
(1) review of the actions of individuals or entities who receive Medicaid reimbursement to determine whether fraud, waste or abuse has occurred;
(2) audit of claims for payment for items or services furnished;
(3) identification of overpayments to individuals or entities receiving federal Medicaid funds; and
(4) education of providers of services, managed care entities, beneficiaries, and other individuals with respect to payment integrity and quality of care.

Third party payers. The DRA amended the list of third party payers named in Soc. Sec. Act §1902(a)(25). The list includes self-insured plans, pharmacy benefit managers, and other parties that may be legally responsible for payment of a claim for health care services or items.

In addition, §1902(a)(25) has been amended to include self-insured plans, pharmacy benefit managers, and other parties that are legally responsible in the list of health insurers that states must prohibit from considering an individual's Medicaid status during enrollment or when making payments for benefits on the individual's behalf. States must take all reasonable measures to determine the liability for payment of a health care claim or service before a payment is furnished by Medicaid. Finally, states are required to provide assurances to the Secretary of HHS that its laws require third parties to provide information to determine health insurance coverage and to cooperate with the payment recovery efforts of the Medicaid state agency.

In addition, under the provisions of the DRA the term "managed care organization" has been substituted for "health maintenance organization."

Eligibility and documentation requirements. States are prohibited from receiving Medicaid reimbursement for any individual who has not provided satisfactory documentation of U.S. citizenship or nationality. This provision, which applies to initial determinations and redeterminations of eligibility for Medicaid, provides a list of acceptable documentation as proof of citizenship, including any of the following:
(1) a U.S. passport;
(2) Certificate of Naturalization;
(3) Certificate of U.S. Citizenship;
(4) a valid state-issued driver's license or other identity document described in section 274A(b)(1)(D) of the Immigration and Nationality Act (but only if the state issuing the license or document requires proof of U.S. Citizenship or a verified Social Security number before issuance); and
(5) any other document specified by the Secretary of HHS that will provide reliable documentation of an individual's identity and proof of U.S. citizenship or nationality.

Alternatively, citizenship or nationality can be established by providing: (1) a birth certificate from the U.S.; (2) a Certificate of Birth abroad; (3) a U.S. citizen identification card; (4) a report of a Birth Abroad of a U.S. citizen; or (5) any other document specified by the Secretary that provides evidence of U.S. citizenship or nationality; **and** (a) any identity document described in section 274A(b)(1)(D) of the Immigration Nationality Act; or (b) any other documents specified by the Secretary in number five above.

For details of the DRA provisions affecting the Medicare and Medicaid programs, see the story on page 7 of this letter. ■

CRS Report for Congress, Side-by-Side Comparison of Medicare, Medicaid, and SCHIP Provisions in the Deficit Reduction Act of 2005, Jan. 27, 2006.

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Unless otherwise noted, all paragraph references are to the CCH Health Care Compliance Reporter.

Sentencing commission reconsiders its commentary on waiver of privilege

Stacey Fahrner, J.D., MPH, Contributing Editor

Language that allows for a reduction in culpability when the attorney-client privilege and work product protections are waived, which was added to Chapter 8 of the Federal Sentencing Guidelines in 2004, is under reconsideration by the U.S. Sentencing Commission. During a public meeting in November 2005, representatives of several organizations, including the American Bar Association, depicted the language as causing deleterious effects on the criminal justice process.

The sentencing guidelines provide for decreases in culpability if a defendant organization has self-reported, cooperated with authorities, and accepted responsibility. The language being reconsidered states in the commentary that "waiver of attorney-client privilege and of work product protections is not a prerequisite to a reduction in culpability score . . . unless such waiver is necessary in order to prevent timely and thorough disclosure of all pertinent information known to the organization."

Detrimental effect of incentives to waive privilege. According to Frank Sheeder, a healthcare compliance lawyer with Brown McCarroll, L.L.P. in Dallas, incentives to waive privilege and protection have a detrimental effect on both the attorney-client relationship and the effectiveness of compliance programs. "Attorney-client privilege goes all the way back to Elizabethan times. It has venerable purposes, like promoting a client's candor in discussions with counsel. Knowing that traditionally privileged communications and work product could be exposed to government enforcers decreases such candor, which diminishes the quality of an attorney's legal advice. Because the Sentencing Guidelines are the basis for the elements of an effective compliance program, resolution of this issue has much broader implications. For example, obviating privilege and work product protection is inconsistent with building the trust and dialogue that are essential to having an effective compliance program."

In a 2005 letter to the Chairman of the Commission regarding the commentary language, the American Civil Liberties Union (ACLU) contended that "organizations will have no choice but to waive these privileges whenever the government demands it, as the threat to label them as "uncooperative" in combating corporate crime-even if the charge is unfounded-could have a profound effect on their public image, stock price and credit worthiness. " The letter went on to state that the routine waiver of privileges could discourage consultation with company lawyers, which would impede the lawyer's ability to counsel on compliance with the law. Internal compliance programs could be compromised because individuals with knowledge would be hesitant to speak candidly with in-house lawyers. Finally, the ACLU argued that routine waiver would place employees in the difficult position of deciding whether to cooperate with an investigation and risk that statements made to the company's lawyers would be turned over to the government, or they could potentially risk their employment by refusing to cooperate.

Sheeder says, "The ACLU has some good points on this issue. Requiring waiver of attorney-client privilege and work product protection is not the only way for cooperating entities to provide information to the government. There are other methods for sharing facts. By pushing for the waiver of attorney-client privilege, government lawyers are really saying that they don't trust private practice lawyers and in-house counsel to provide information cooperatively in a way that honors the attorney-client relationship. That's unfortunate."

Comments sought. The Commission is seeking comments from the public on whether the language is having unintended consequences, how the commentary has had adversely affected the application of the sentencing guidelines and the administration of justice, whether the language should be deleted or amended, and if it should be amended, in what manner.

The full text of the ACLU letter, which is supported by various other trade and professional organizations, can be viewed at www.aclu.org/crimjustice/sentencing/10231leg20050303.html. ■

Notice, 71 FR 4781, Jan. 27, 2006, Health Care Compliance Reporter, ¶760,021; ACLU Letter, March 3, 2005.

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On The Front Lines

Practitioners Discuss IRS Focus on Exempt Organizations, Provide Solutions

by Larry Perlman, CPA, J.D., LLM, Contributing Editor

Congress and the Internal Revenue Service have turned up the level of scrutiny on tax-exempt organizations, including requiring more reporting and documentation relating to community benefits, compensation, conflicts of interest and arrangements. Exempt organizations must ensure that they have established effective governance procedures to monitor compensation and take action in the case of excess benefit transactions.

"There definitely is a spotlight on exempt organizations to make sure we're doing what we're supposed to be doing; and everyone is interested, from the public to the Internal Revenue Service (IRS) and Congress,"noted Linda Mason, Ernst & Young LLP, Miami. Mason, along with other practitioners, examined Form 990 changes, the new intermediate sanction regulations, compensation audits by the IRS, transactions with board members and the hospital community benefit at the Ernst & Young 15th Annual Health Sciences Tax Conference in Las Vegas, Nevada.

Form 990 Changes

Mason explained changes to Form 990 for the organizations with tax years beginning in 2005 (filing starting in 2006), including the additional information required. The 990 was in draft form at the time of the conference.

Form 990 now includes more extensive reporting of compensation, arrangements and conflicts of interest with employees, officers, directors and trustees, and independent contractors. "They are really drilling down. If you don't have a conflict of interest policy, I strongly suggest you adopt one," Mason said.

Information on foreign activities, such as interests in financial accounts in foreign countries, is now a required disclosure on the Form 990 rather than the Form 990-T, Exempt Organization Business Income Tax Return. Therefore, this information will be available for public inspection. "Since 9/11, the IRS and Congress have been very interested in exempt organizations' foreign activities," she said

The form also asks supporting organizations which type they are.“ The IRS is most interested in Type III supporting organizations (operated in connection with the supported organization). [Organizations] need to review their application for exemption and confirm whether anything has changed that would affect what type of supporting organization they are." "There have been a lot of changes, and [tax preparers] will need the information in a timely manner. It's going to be an interesting filing season," Mason predicted

Intermediate Sanctions

In September, the IRS released proposed regulations clarifying the impact on exempt status under IRC Code Section 501(c) (3) if an organization benefits a private interest or engages in an excess benefit transaction.

One key provision of the regulations, according to Joyce Hellums, Ernst & Young, Austin, is that in determining whether to revoke exempt status, the IRS will consider all facts and circumstances, including whether the entity has implemented safeguards that are reasonably calculated to prevent future violations.

The proposed regulations also make it clear that the IRS may assign greater or lesser weight to some factors than to others. Factors such as (1) whether the organization has implemented safeguards that are reasonably calculated to prevent future violations; and (2) whether the excess benefit transaction has been corrected or the organization has made good faith efforts to seek correction from the disqualified persons who benefited from the excess benefit transaction will weigh more strongly in favor of continuing to recognize exemption when the organization discovers the excess benefit transaction and takes action before the IRS discovers the excess benefit transaction. The IRS is going to evaluate whether the exempt organization has developed good governance procedures.

Hellums advised that corrective steps may include:

- removing fiduciaries who allowed the private inurement to occur;
- appointing new, disinterested fiduciaries who will perform due diligence and avoid conflicts of interest;
- taking aggressive action to recover any excess benefits from insiders; and
- implementing policies and procedures to prevent future violations.

Ernst & Young recommends that the organization implement a process to determine which persons have been disqualified and monitor it on a frequent basis. Moreover, it is

important for the organization to educate new board members and key employees about proper procedures.

To establish the rebuttable presumption of reasonableness, Ernst & Young recommends that the compensation committee (1) get outside advisors, and (2) contemporaneously document its decisions. In addition, the compensation committee should be independent. Jim Steen, Ernst & Young, Pittsburgh, agreed. "Go back and look at compensation committee members to make sure they are as independent as you think they are."

Executive Compensation

The IRS has sent out over 1,800 letters as part of an initiative that targets compensation of employees of charitable organizations, especially executives. A number of the letters have gone out, with many cases in examination. Katherine Kurtzman, Ernst & Young, Chicago, said she is surprised as to the depth and breadth of what the IRS is asking. "The IRS may be educating [themselves and the exempt organizations], expecting problems, and may be less generous in the future."

She suggested making sure to disclose the organization's officers, directors, trustees, and key employees, on a legal entity basis. In addition, it is important that legal counsel, human resources, the chief executive officer, chief financial officer, and all appropriate people look at and approve the tax return to make sure it includes every compensation item. "Prepare your return early; it gives others [in the organization] time to look at it."

"Best practices. . . for the full board include: (1) approval of the chief executive officer's compensation annually, and (2) review of the entire staff's compensation program periodically."

Best practices. Kurtzman said a best practice is for the board to hire an independent compensation consultant. The board and the independent consultant should confirm that all items of income are included in the comparison, the job descriptions agree to the title, the comparables make sense, and the approval noted in the minutes can be audited. Kurtzman cited some reasons—including car allowance issues, spousal travel, gifts, cell phone use and bonus adjustments—when the compensation approved was not what was paid.

The personal portion of an employer-provided cell phone must be included on the employee's W-2. Kurtzman said that it may be easier or "cleaner" if the employee pays for the phone and submits the business portion for reimbursement. Also, consider similar treatment for credit cards. She suggested having the card in the employee's name. Having the employee request reimbursement avoids inadvertent errors and allows for better monitoring.

She said that another best practice is for officers, if previously attending the meeting, to recuse themselves from the debate or voting regarding their compensation because the rebuttable presumption of reasonableness is not available if this does not occur. The IRS may "presume that these individuals were present at the meeting unless the minutes reflect otherwise."

Howard Levenson, National Director of Ernst & Young's Exempt Organizations Tax Practice, based in Washington, D.C., offered other compensation best practices at another conference session. Those for the full board include: (1) approval of the chief executive officer's compensation annually, and (2) review of the entire staff's compensation program periodically.

IRS role. With the letters, the IRS wants to educate the public and exempt organizations to make sure organizations are following the rules with appropriate documentation. The IRS also is seeing what is out there as they go through this whole process, said Michael Vecchioni, Ernst & Young, Detroit.

Because of the program, he said that for FY 2006 the IRS is considering a compliance check program for hospital community benefit practices. In addition, the Form 990 has added compensation disclosures.

"Some common items the IRS or organizations are finding as they go through this are insider loans with no or low interest and sloppy documentation, and sales or exchanges to insiders with favorable terms. Also, courtesy discounts in the health-care field have not been picked up properly as compensation," Vecchioni said

The IRS wants copies of W-2s, expense reports, severance arrangements, employment contracts, job descriptions, compensation studies done, and minutes where compensation plans approved, said Mike Sims, Vice President, Controller, Premier Health Partners, Dayton, Ohio, who had two hospitals go through the examination process. "Total compensation has to be approved by the board, not just salary, not just bonuses." Documenting why you do something is critical, Vecchioni asserted.

Transactions with Board Members

Schedule A, Part III, of the Form 990 asks whether the exempt organization has engaged in certain transactions with persons such as the organization's officers, directors, trustees. A detailed statement must accompany the return for transactions listed in the form, such as the sale, exchange, or leasing of property, loans, or reimbursement of expenses (if more than $1,000). "These transactions do exist and they aren't necessarily bad," Kurtzman said. "Just disclose them." She suggested that organizations resolve conflict of interest statements with

negative responses. All individuals should complete these forms. "No exceptions," she said.

Community Benefit

In May 2005, Sen. Charles Grassley (R-Iowa) sent a letter to 10 hospitals, asking about their community benefit, along with questions on patient charges, debt collection, joint ventures, and their definition and method of quantifying charity care.

A problem arises because there is no standard definition or formula to quantify community benefit. "It is a complex concept that can be politicized," said Renotta Young, Mayo Clinic, Rochester, Minnesota.

The value of the nonprofit hospitals' community benefits and tax-exempt status also are subject to much closer scrutiny in the states. Some states, such as Massachusetts, have a specific formula and require nonprofit hospitals to report community benefits. "Clearly, state attorneys general have been active and can be more active" in the area, according to Thomas Neubig, Ernst & Young, Washington, D.C.

The value of charity care includes direct care provided to uninsured and underinsured patients, unprofitable service lines and facilities that are part of the hospital's charitable mission, and bad or forgiven debt write-offs. The valuation of tax-exempt status analyzes federal tax liability, state and local tax liability, and non-tax costs. Non-tax costs include no longer being able to benefit from the lower interest rates of tax-exempt bond financing, loss of fundraising, higher postage, and loss of volunteer labor.

Discussion of valuing community benefit has not included the economic and fiscal benefits provided by a local hospital to the local community, Neubig said. "I would include these benefits. If you are dealing with a local community, that perhaps has your property tax exemption under consideration ... [officials] are interested in the jobs, income and taxes, and would rather have a nonprofit hospital in their county or city than in an adjacent town or city. It's a public relations tool more than just a compliance obligation. Looking at the local benefits is something you should have in your arsenal," he said. "It is important to quantify the hospital's community benefit. It not only fulfills a compliance obligation, but also is an opportunity to present the hospital's mission and vision. Include it on the Form 990, as well as other community presentations."

A review of the value of tax-exempt status does not have to be done at detailed level, Neubig advised, but can be at a high-level, under attorney-client privilege. The review would provide management and the board of directors an estimate of the value of the current tax-exempt status.

Conclusion

Tax practitioners discussed the IRS focus on tax-exempt organizations and provided solutions the organizations might implement to address issues that might arise. The practitioners noted that Form 990 now includes more extensive reporting of compensation, arrangements and conflicts of interest with employees, officers, directors and trustees, and independent contractors, and information on foreign activities.

In relation to the intermediate sanction regulations, the practitioners stated that in determining whether to revoke exempt status, the IRS will consider all facts and circumstances, including whether the entity has implemented safeguards that are reasonably calculated to prevent future violations. As for compensation of employees of charitable organizations, practitioners noted that it is important that all appropriate people look at and approve the tax return to make sure it includes every compensation item.

If the exempt organization has engaged in certain transactions of more than $1,000 with persons such as the organization's officers, directors, or trustees, practitioners noted that a detailed statement must accompany the return for transactions listed in the form. Finally, the practitioners addressed the community benefit stating that it is important to quantify the hospital's community benefit.

Human Resources

Referrals between LTCHs, acute care hospitals raise fraud concern

Stacey Fahrner, J.D., MPH, Contributing Editor

CMS provided a warning of potentially fraudulent referral arrangements between acute care hospitals and long term care hospitals (LTCHs) within hospitals (HwHs), LTCH satellite hospitals (same campus), and LTCH stand alone hospitals in the fiscal year (FY) 2007 proposed rule for the LTCH prospective payment system (PPS). In particular, CMS is concerned with efforts to circumvent the special payment provisions, which mandate that no more than 25 percent of a satellite or HwH's Medicare discharges may be admitted from the host hospital. The warning could indicate future changes in the LTCH PPS affecting existing financial arrangements or increased scrutiny of referral patterns from the Office of Inspector General (OIG).

History of LTCH special payment provisions. Since their inception, CMS has expressed concerns that patient shifting between acute care hospitals and LTCH HwHs or satellite hospitals has been based primarily on financial rather than medical criteria. CMS contended in the 1995 inpatient PPS final rule that HwHs were operating as step-down units of acute care hospitals, which would lead to two Medicare bills being submitted for one episode of care. Once a patient, who is still being treated for an acute illness, is discharged from the IPPS acute care hospital to the LTCH a second admission and Medicare payment is generated that would not occur but for the co-location of the LTCH. In addition, the acute care hospital inappropriately incurs lower costs under IPPS because the course of acute treatment is not completed in the hospital. Such a scenario undercuts the IPPS diagnosis related group system, which is based on averaging low and high cost patients treated in an acute care setting.

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In response to these concerns, CMS instituted separateness and control regulations which required the establishment of a clear division between the host acute care hospital and the LTCH HwH or satellite hospital. CMS enacted additional payment adjustments in the 2005 IPPS final rule that allowed only 25 percent of the Medicare discharges to be admitted from the host acute care hospital. When the limit is violated, the payment is adjusted to the lesser of the otherwise payable amount under the LTCH PPS or the equivalent to what Medicare would pay under the IPPS.

New concerns. Recent comments by the Medicare Payment Advisory Committee (MedPAC) and other industry groups suggest that the intent of the 25 percent rule is being thwarted by creative patient-shifting and transporting schemes. For example, in communities where there are multiple LTCH HwHs or LTCH satellites, acute care hospitals are arranging to cross-refer to another's co-located LTCH (satellite or HwH), which is considered by CMS to be inappropriate patient shifting. Another scheme entails admitting a patient from an acute care host hospital then transporting the patient to another location of the same LTCH for special treatment. The transporting scheme side steps the payment adjustment because it is currently enforced based on the location of the satellite LTCH. Thus, when a patient is transferred to another off campus location, the 25 percent rule does not apply.

Free-standing LTCH. In the FY 2007 proposed rule, CMS also notes that the "functional separateness" requirements apply to more than just HwHs and satellites. There are new concerns regarding the source of admissions for free-standing LTCH. Specifically, CMS believes that "the extent to which a LTCH accepts patients from outside sources can be an important indicator of it's function as a separate facility, not merely a unit of another hospital." Studies show that many free-standing LTCHs have established close ties with acute care hospitals, which is reflected in admission statistics. For example, the FY 2004 and FY 2005 MedPAR files indicate that the majority of free-standing LTCHs had at least 25 percent of the Medicare discharges admitted from a single acute care hospital. Nearly 30 percent of free-standing LTCHs had over 50 percent of their Medicare discharges admitted from a single source.

Potential corrective actions. In response to these concerns, CMS has stated that they will continue to monitor patient shifting activities between host hospitals and HwHs or satellites paying special attention to inappropriate cross-referrals, which could warrant an investigation by the OIG. In addition, CMS will analyze patient claims data for acute care patients who are admitted to free-standing LTCHs to evaluate whether Medicare is paying twice for a single episode of care. Appropriate adjustments to the LTCH PPS addressing free-standing LTCHs are already being considered. ■

Proposed rule, 71 FR 4648, Jan. 27, 2006.

Legislation

Medicaid, Medicare spending cuts part of budget bill

Paul T. Clark, Contributing Editor

Legislation that will reduce federal spending by $39 billion over the next five years, was signed by President Bush on February 8, 2006. The Deficit Reduction Act of 2005 (DRA) would reduce Medicare spending by $6.4 billion and Medicaid spending by $4.7 billion from 2006 to 2010, according to estimates from the Congressional Budget Office (CBO).

Medicare changes. In three separate reports issued at the end of January, the CBO documented the revenue and enrollment changes in the Medicare and Medicaid programs that would likely result under the legislation.

- *Hospital quality*—Hospitals that do not report certain quality-related data face a 2 percent reduction (up from a 0.4 percent reduction) in payments for inpatient services, starting in 2007. This change will reduce Medicare spending by $300 million from 2006 to 2010.
- *Physician services*—Planned reductions in payment rates for physicians' services in 2006 that were eliminated under the DRA will increase Medicare spending by $1.5 billion in 2006 and by $7.3 billion from 2006 to 2010. The DRA, however, requires that the cost of increasing payment rates for physicians' services be offset by future reductions in those rates. Consequently, Medicare's payments for physicians' services will be below current-law levels from 2010 through 2015. Assuming that occurs, CBO estimates that Medicare spending will be reduced by about $400 million from 2006 to 2015.
- *DSH adjustments*—A clarification in the counting of Medicaid days for purposes of disproportionate share adjustments will reduce Medicare spending by $1.2 billion from 2006 to 2010.
- *Imaging services*—The DRA exempts from Medicare's budget-neutrality rules scheduled reductions in payments for certain imaging services that are performed on contiguous body parts. Exempting these reductions from the budget neutrality rules would allow savings resulting from the new payment rates to decrease overall spending rather than being used to increase payment rates for other services. These changes will reduce Medicare spending by $2.8 billion from 2006 to 2010.
- *DME ownership*—Modified ownership rules for durable medical equipment will reduce Medicare spending by $700 million from 2006 to 2010.
- *Home health*—A reduction in payment rates for home health services will decrease Medicare spending by $2 billion from 2006 to 2010.
- *Part C*—Modifications in the way payments to Medicare Advantage plans are adjusted to reflect differences in expected costs associated with the health status of certain beneficiaries will reduce spending by $6.4 billion from 2006 to 2010.

Medicaid changes. Changes in the Medicaid program will limit payments for certain outpatient prescription drugs, change rules and penalties related to asset transfers, improve program integrity, increase cost sharing, and expand home- and community-based services for people receiving long-term

care. Additional changes include: (1) state Medicaid programs would pay pharmacists for prescriptions based on average wholesale price rather than average manufacturer price and (2) states would be able to charge beneficiaries with family incomes over 150 percent of poverty co-payments up to 20 percent of the cost of medical services.

- *Asset transfers*—Changes regarding asset transfers and qualification for Medicaid nursing services will reduce Medicaid spending by $2.4 billion from 2006 to 2010.
- *Prescription drugs*—Limiting payments for certain outpatient prescription drugs and increasing the rebates that Medicaid receives from drug manufacturers will reduce Medicaid spending by $3.9 billion from 2006 to 2010.
- *Program integrity*—Provisions designed to improve payment integrity in the Medicaid program will reduce Medicaid spending by $822 million from 2006 to 2010.
- *Cost sharing*—Granting greater flexibility to states in imposing cost sharing by recipients, and permitting states to limit benefits to certain recipients, will reduce Medicaid spending by $3.2 billion from 2006 to 2010. ■

For a discussion of the False Claims Act provisions of the DRA, see story on page 1 of this newsletter.

Congressional Budget Office, Cost Estimate on S.1932, The Deficit Reduction Act of 2005, Jan. 27, 2006; CBO Letter, Jan, 27, 2006; CBO Letter, Jan. 31, 2006; CCH Washington Bureau, Feb. 2, 2006.

Bush's proposed Medicare cuts faces opposition on Capitol Hill

by Catherine Hubbard, Contributing Editor

Although President Bush's fiscal year 2007 budget proposal of $2.77 trillion includes an estimated $450 billion in funding for Medicare benefits, the budget also includes $36 billion in spending reductions for Medicare over five years and $105 billion over 10 years. The Medicare reductions are part of Bush's overall goal of cutting the federal deficit in half by 2009.

Cuts would occur in part by reductions in hospital payments and nursing home payments and increased premiums for higher income beneficiaries. The budget also would save $12 billion from Medicaid over the next decade. Specific reforms have been proposed to help sustain Medicare in the long term. HHS Secretary Michael Leavitt stated that "Medicare will continue to grow, but at a slower rate." In addition, CMS Administrator Mark McClellan said the budget would help delay a trigger that would apply across-the-board cuts to the program. Last year, the Medicare Trustees forecast the trigger would be reached in 2012, but that estimate would move to 2017 under the proposed budget.

The proposed budget faces a tough battle in Congress in light of recently passed cuts to the Medicare and Medicaid programs in the Deficit Reduction Act. "Congress just finished reducing the growth of Medicare and Medicaid by $11.1 billion over the next five years, and it wasn't an easy legislative accomplishment,"" said Senate Finance Committee Chairman Charles Grassley (R-Iowa). "Any more reductions of a significant scope could be difficult this year." ■

CCH Washington Bureau, Feb. 6, 2006.

In the News

Dentist fined and sentenced for Medicaid fraud

A dentist in Illinois, who had performed unnecessary dental procedures on patients and billed Medicaid for services not performed or not performed as indicated, was found guilty in a jury trial on charges of mail fraud and health care fraud. The dentist has been sentenced to 63 months in prison and ordered to pay $827,000 in restitution and a $20,000 fine.

OIG Release, Jan. 23, 2006. ■

DOJ files antitrust action

The Antitrust Division of the Department of Justice (DoJ) filed a suit in U.S.District Court in Charleston, West Virginia, alleging that an agreement between a Charleston hospital and another corporation operating hospitals in the area is anti-competitive. The agreement prevents the corporation from developing a cardiac surgery program. The DoJ simultaneously filed a consent decree with the court that would annul the anti-competitive portion of the agreement and would prevent the hospital from entering into other agreements that would prevent another facility from developing cardiac surgery services. ■

DoJ Press Release, Feb. 6, 2006.

AWP litigation class certified

A federal judge in Massachusetts has approved class certification in a suit alleging that several major pharmaceutical manufacturers overcharged the government by inflating the average wholesale price (AWP) of their drugs. The AWP is used by the government to set reimbursement rates for federal healthcare programs including Medicare and Medicaid. Approved classes include people who made co-payments for certain Medicare Part B drugs , third-party payors who made reimbursements for drugs purchased in Massachusetts, and people or third-party payors who made reimbursements based on contracts outside of the Medicare context using AWP as the pricing standard for purchases in Massachusetts. ■

Consolidated Order Re: Motion for Class Certification, D. Mass., Jan. 30, 2006.

IHA campaigns against Illinois charity care bill

The Illinois Hospital Association (IHA) has launched an aggressive campaign to oppose the Illinois Attorney General's recent legislative proposals that would require all not-for-profit hospitals to spend at least 8 percent of operating costs on charity care (see story in Volume 9, Issue 3 of the *Health Care Compliance Letter*). The IHA has asked its members to write state representatives highlighting charitable programs and services currently in place as well as the potential

“devastating impact” the proposed requirement would have on a hospital's ability to serve the community. Members also have been urged to reach out to other organizations with which they are affiliated to help in the campaign. ■

The Reporter, Illinois Hospital Association, Feb. 3, 2006.