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Drug company settles Medicaid prescription drug allegations

CVS Caremark Corp. (CVS) has agreed to pay more than $21 million to the United States and $15.6 million to 23 states to resolve a False Claims Act whistleblower suit alleging improprieties in its Medicaid prescription drug claims. The whistleblower suit alleged that from April 2000 through December 2006, CVS improperly switched Medicaid patients from the cheaper tablet version of Ranitidine to the more expensive capsule version solely to increase its reimbursement rate. The switch increased the price substantially while adding no medical benefit and violating federal and state regulations, according to the Department of Justice. Ranitidine is the active ingredient of the drug Zantac®.

The Food and Drug Administration does not consider different dosage forms of the same compound the same and, therefore, requires a direct order from a physician before a pharmacy may switch a medication from tablet to capsule form. In addition, state and federal regulations permit a pharmacist to switch between medications (such as from a name brand to a similarly formulated, equally effective generic drug) for a Medicaid beneficiary only if two conditions are met: (1) the replacement drug is considered therapeutically and pharmaceutically equivalent; and (2) the unit price for the replacement drug is less than the unit price for the medication originally prescribed. In this case, for example, it was alleged that by substituting Ranitidine capsules for the 150 mg. tablets that were prescribed between December 15, 2000, and April 1, 2001, CVS was able to charge the Illinois Medicaid program $79.80 instead of $17.10 per 60-tablet prescription, for a difference of $62.70.

"Switching medication from tablets to capsules might seem harmless, but when that is done solely to increase profit and in violation of federal and state regulations that are designed to protect patients, pharmacies must know that they are subjecting themselves to the possibility of triple damages, civil penalties and attorney fees," U.S. Attorney for the Northern District of Illinois, Patrick Fitzgerald explained.

CVS also agreed to enter into a five-year corporate integrity agreement with HHS as part of the settlement (*see Health Care Compliance Reporter* ¶420,466). "The CVS Corporate Integrity Agreement includes comprehensive auditing of the company's Medicaid reimbursement," HHS Inspector General Daniel Levinson, said adding that the settlement should "serve as a reminder of our commitment to work with our federal and state partners to root out schemes to generate illegal profits from Medicaid programs at the expense of taxpayers and vulnerable recipients." ■

U.S. Attorney for the Northern District of Illinois Press Release, March 18, 2008.

Wolters Kluwer Law & Business

State high court upholds patients' right to review adverse event reports

In a recent decision, the Florida supreme court found that a state constitutional amendment granting patients the right to review records of health care facilities' or providers' adverse event reports is self-executing and can be applied retroactively. The court also declined to invalidate, in whole, a state statute enacted shortly after the amendment that contained provisions limiting the access rights granted to patients through the amendment.

Background. The state constitutional amendment (amendment 7) was passed by Florida voters in November 2004. A ballot summary accompanying the amendment explained that "[c]urrent Florida law restricts information available to patients related to investigations of adverse medical incidents, such as medical malpractice. This amendment would give patients the right to review, upon request, records of health care facilities' or providers' adverse medical incidents, including those which could cause injury or death." In June 2005, shortly after amendment 7 was passed, the Florida legislature enacted legislation dealing with the same subject matter as amendment 7 (the legislation was codified at Fla. Stat. §381.028).

In two separate medical malpractice actions against hospitals in the state, patients sought production of documents purportedly discoverable under amendment 7. In one case, they sought records of the investigation of the adverse medical incident at issue; in the other, they sought records related to the selection, retention, or termination of one of the hospital's physicians. In both cases, the hospitals objected to the production of the records pursuant to various statutory privileges existing prior to the amendment's passage. Both trial courts overruled the hospitals' objections to production of the records, and the hospitals appealed the courts' decisions.

Following conflicting decisions by the first and fifth district courts of appeal, the Florida supreme court considered the following three issues for final resolution: (1) whether amendment 7 is self-executing; (2) whether amendment 7 can be applied retroactively; and (3) whether the provisions of the statute passed a year after amendment 7 were constitutional.

Self-execution. The test to determine whether a constitutional provision should be construed as self-executing is whether the provision lays down a sufficient rule by which the right it gives or the purpose it is intended to accomplish may be determined, enjoyed, or protected without the aid of legislative enactment. In amendment 7, all key terms were defined, and the definition of the phrase "have access to any records" indicates that it is to encompass current document production procedures as provided "by general law." Further, the court noted that the amendment expressly declared itself to be effective upon passage. Accordingly, the supreme court held that the amendment is self-executing and its terms enforceable as of the date of its passage.

Retroactive application. To determine whether amendment 7 should be retroactively applied, the court asked first if the relevant provision provides for retroactive application, and second if such application is constitutionally permissible. The terms of the amendment indicate that it was intended to apply to existing records. Based on a plain reading of the text, the electorate would have logically assumed it would give patients an immediate right of access to existing medical records.

Prior to the amendment, medical providers received at best only an expectancy that legislative policy favored limited access and use of the records of certain investigations into reported instances of questionable medical conduct by peer review bodies. This expectancy, the court reasoned, never rose to the level of a substantive vested right and, therefore the amendment does not violate the due process rights of medical providers. Thus, amendment 7 can be applied retroactively so as to gain access to records that were in existence prior to passage of the amendment and that were protected under prior law.

Constitutionality of statute. According to the court, the statute enacted after amendment 7 contained four provisions contravening the broad access rights granted by the amendment. Rather than invalidating the entire statute, the court concluded that the offending sections should be separated from the remainder of the statute. Absent the conflicting sections, the court found that the statute fulfills the purpose of implementing amendment 7 and is a workable and helpful statute. ■

Florida Hospital Waterman, Inc. v. Buster, S.Ct. of Florida, Nos. SC06-688, SC06-912, March 6, 2008, Health Care Compliance Reporter ¶800,469.

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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Experts reveal tips for completing the revised Form 990

The Internal Revenue Service's (IRS's) 2008 Form 990 remains more of a disclosure document than a tax return in that it emphasizes information about an organization's activities and governance structure. "In some places it's a place to confess your sins," according to Linda Mason of Ernst & Young, Miami, Florida. The newly revised Form 990 is the form's first comprehensive update in 25 years and was discussed extensively at a recent Ernst & Young Health Sciences Tax Conference in Las Vegas, Nevada.

Exempt organization governance. On the Form 990, the IRS has increasingly asked nonprofits about their governance policies and practices, while also providing guidance in the area (*see* www.irs.gov/pub/irs-tege/good_governance_practices.pdf). According to the IRS, good governance practices include having a written and well-articulated mission statement, a document retention policy, code of ethics and whistleblower policies. Good governance also includes making sure that the Form 990, annual reports, and financial statements are accurate and available for public inspection, and ensuring that fundraising solicitations meet state and federal requirements and are accurate.

Both the IRS and the Panel on the Nonprofit Sector (created by Independent Sector at the request of the Senate Finance Committee) have provided best practices that place a strong emphasis on written policies. "Please don't write policies that you don't intend to use or enforce," warned Katherine Kurtzman, Ernst & Young, Chicago, Illinois.

Writing a document retention policy may be more difficult than you think, Kurtzman said. In addition, "[i]f you have a net operating loss carryforward, a seven-year [retention policy] may not be enough. For example, we can't automatically presume that after seven years we can throw everything away. If you have tax-exempt bonds, you may have to keep things for an eternity. When you're writing the policy, take some time to think about how it's going to work."

The 2008 Form 990 includes Section VI, Governance, Management, and Disclosure. All organizations must answer each question in the section, even though certain policies and procedures are not required under the Internal Revenue Code. It is helpful to know what the IRS thinks the right answer is. "It won't be a complete return if you don't answer them," Kurtzman advised.

Community benefit. Tax-exempt hospitals must meet a community benefit standard. This standard will be disclosed on the 2008 Form 990's new Schedule H, Hospitals. The IRS rationale for adding the schedule is to promote transparency.

Part I of the schedule (optional for 2008) is a community benefit report that includes the number of activities or programs, persons served, total community benefit expense, net community benefit expense, direct offsetting revenue, and community benefit as a percentage of total expense. "I'm sure they'll come up with statistics with these percentages," said Kathy Pitts, Ernst & Young, Birmingham, Alabama.

Another question, which concerns charity care, allows an organization to describe its charity care policy if the organization answers that it has one. "If you answer 'no,' maybe you don't get to tell your story," Pitts said.

The general information part of Schedule H includes questions on how a hospital assesses the health care needs of the communities it serves, how the organization's patient intake process informs and educates patients regarding eligibility for assistance, and its community building activities. There also is room for other information important to describing how hospital facilities further the organization's exempt purpose.

In response to a question from the audience on community benefit costs that may fluctuate from year to year, Pitts said that in an audit you can point to other years, but she has seen no evidence of the IRS looking at an organization's cost trends. Mason added, "In general, each year stands on its own."

Compensation. Regarding the 2008 Form 990, Joyce Hellums, Ernst & Young, Austin, Texas, said that one of the few beneficial changes in compensation reporting is the increased reporting requirement from $50,000 to $100,000 for the highest paid employees. In addition, the IRS has reduced an organization's burden by clarifying the requirement for reporting compensation for former officers, directors, and key employees (FODKEs). Organizations only have

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On The Front Lines

Understanding compliance legal standards as a key element in a compliance program

by John E. Steiner Jr., Esq., Editorial Advisory Board Member

The main objective of this article is to assist the reader in thinking about or considering "compliance legal standards" as a critical element in the design, implementation, and administration of a formal compliance program. In the context of this article, "compliance legal standards" are the standards of conduct expected of a regulated entity. The applicable standards are found in legal authority (i.e., statutes and regulations), as well as the sanctions that may be imposed for noncompliant conduct. Several examples are provided in this article to illustrate this way of thinking, explaining, and acting upon compliance standards within an organization.

The essential elements of an effective compliance program are published in the U.S. Federal Sentencing Guidelines, the HHS Office of Inspector General (OIG) Model Voluntary Compliance Guidance documents, and periodic updates to those documents. Those guidance documents provide a framework, but not many specifics, for thinking about or considering applicable compliance legal standards.

Roots of compliance legal standards

Most compliance requirements are rooted in statutory or regulatory authorities. For the sake of this article, a compliance legal standard can be analyzed in two steps. First, the legal authority states what is required. For example, the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule requires a "covered entity" to issue a Notice of Privacy Practices to individuals who seek treatment from the covered entity.

Second, the legal authority includes sanctions that may apply when a legal requirement is violated. Under the HIPAA Privacy Rule, many of the legal compliance standards are reasonably clear and straightforward, as in the case of issuance of a Notice of Privacy Practices. Other Privacy Rule requirements, however, may be less clear and, if not fulfilled, may lead to a civil sanction (*i.e.*, a monetary fine) for "willful neglect" of an individual's federally recognized privacy rights. A covered entity may face a civil sanction, for example, if its workforce fails to understand and properly apply the "minimum necessary" standard for the use or disclosure of protected health information. Therefore, the privacy officer should understand how the HHS Office for Civil Rights is likely to interpret and apply the "willful neglect" compliance standard under HIPAA. This example illustrates both an affirmative compliance requirement (*i.e.*, educating and training the workforce on the "minimum necessary" standard) and the applicable legal compliance standard for imposing a civil sanction.

Further, under the HIPAA Privacy rule, a "knowing" violation of individual privacy rights may subject the offender to criminal penalties. For example, improper access to or disclosure of an individual's protected health information for personal financial gain can be prosecuted criminally.

The point is that there are many compliance legal standards in health care, and those standards should be assimilated and applied by compliance professionals as a regular part of their duties. This is not merely an academic exercise. As a reference point, it is important to remember that the question underlying the Federal Sentencing Guidelines is whether the corporate compliance program is effective in reducing the likelihood of criminal conduct by the organization and its employees, as well as working for the long term benefits of patients.

Another practical example that rises to the top when thinking about compliance legal standards involves antitrust law. Many health care professionals, including seasoned administrators and practicing physicians, are not fully aware of the substance of those laws, let alone how they are applied in practice. A common antitrust risk area is price fixing among competitors, which is referred to as a *per se*, or fairly automatic, criminal antitrust violation. It usually is the responsibility of the legal and compliance offices to identify the likelihood of price fixing discussions by or between the organization's agents and others. Once that risk is identified, crafting the internal guidance or policies for appropriate members of the workforce is the next major charge to those offices. Thereafter, the effectiveness of policies adopted to address the risk of illegal conduct, such as price fixing activity, must be monitored and audited to ensure effective implementation. This is hard work and requires constant vigilance.

Broad-based awareness of compliance standards is essential

For a compliance program to be effective, the work required to identify, prioritize, and act upon legal compliance standards requires a collaborative effort. The "collaborators" should include senior level management, lawyers (both in-house and outside), physician leaders, and others in positions of authority in the organization. The "tone at the top" must emphasize compliance. If high level individuals within an organization lack a broad based understanding of compliance legal standards, the compliance program may be compromised at the outset. In addition, high-level support of formal compliance programs should promote meaningful risk assessments and appropriate follow-through to achieve reasonable compliance. Without these features (*i.e.*, awareness of applicable standards and establishment of risk priorities), the compliance program likely will be poorly understood by its most important constituents.

Another example that comes to mind is one that engages the chief financial officer (CFO) and many of his or her direct reports—that is, the compliance standard related to "false" cost reports. That standard has many ramifications. Following an audit, there may be disallowances of specific items in a cost report. There may be more serious risks associated with "certification" of a cost report that contains material inaccuracies, in which case a False Claims Act case might be pursued against an official who certified to the accuracy of a cost report. Again, consistent with the theme of this article, a two step analysis is involved. First, the applicable cost reporting standards must be considered to gauge the accuracy and reasonableness of individual items in the cost report. Second, misstatements in a cost report need to be interpreted and understood. Misstatements are likely to be "material" to a CFO's certification of the accuracy of the entire cost report. If the CFO is constructively considering compliance legal standards in this manner, he or she likely will be an advocate for an active compliance program.

Members of the compliance committee and others in leadership positions should appreciate and understand the significance of compliance risk areas (*i.e.*, the compliance legal standards) as the related standards apply to their individual job responsibilities as well as the organization as a whole.

Compliance legal standards change

Courts, legislatures, and regulatory agencies continuously interpret, amend, and issue guidance on the "meaning" or "spirit and intent" of a law or regulation. Thus, the legal compliance standards that apply to regulated entities (*e.g.*, hospitals, nursing homes, device companies, physicians, etc.) are often less than clear. Most regulatory standards can be improved over time. They certainly are not static. In fact, while the standards may appear to be easy to state in plain language, they are not always easy to translate and apply, particularly in the complex, rapidly changing world of health care delivery. Oversight and investigatory agencies usually are early in the line to assess whether a law or regulation has been interpreted and implemented properly. In some cases, a relator or "whistleblower" may be the first to attempt to do so. In other cases, members of the workforce may be the first to attempt to apply a compliance standard as they interpret it.

"[T]here are many compliance legal standards in health care, and those standards should be assimilated and applied by compliance professionals as a regular part of their duties."

Regardless of who is "first in line" to voice an opinion on a given legal requirement, another facet of "considering compliance standards" involves thinking about the proof issues related to succeeding in a fraud case. There is a well developed and complex area of fraud law that is only briefly mentioned here. That area of the law deals with procedural rules that address the specifics that must be contained in a plaintiff's written pleadings submitted to a court. The key point is that under Rule 9(b) of the Federal Rules of Civil Procedure, a fraud allegation must be pled with "particularity." This is another example of a compliance standard that may be an issue in a False Claims Act case. For that reason, the information that a prosecutor or private relator's counsel includes in a description of the alleged fraud or false claim can be important.

Rule 9(b) requires identification of specific claims and an allegation of why the claims are "false" to support a fraud allegation. Generalized statements or vague assertions of suspected fraud will not meet that standard. For example, a coder may honestly believe that fraud is being committed if her supervisor frequently changes a coding decision to support a claim for medical services. Yet, the concerned coder may have only a rudimentary, or no, knowledge of the pleading "standard" set forth in Rule 9(b), while a compliance officer may well consider Rule 9(b) and court decisions interpreting that rule when dealing with specific compliance issues. Likewise, the compliance officer may discuss those pleading "standards," as needed, with counsel and senior management. In short, the concerned coder may be wrong in his or her perception of fraudulent activity.

As illustrated above, the design of a sound compliance program requires consideration of many risk areas and as-

sessments. There also are many variations of legal standards associated with statutory and regulatory requirements. It is important to think about these legal underpinnings of compliance requirements. That thought process allows the compliance officer to gauge organizational risk awareness, the culture of an organization towards compliance, and probable levels of risk.

Research compliance: Multi-faceted compliance legal standards

The health care research arena involves numerous compliance risks to which the suggestions in this article are particularly relevant and should be applied. The numerous legal requirements associated with research (both basic and human subject) can be arranged in two broad categories: financial and nonfinancial. In turn, each category merits careful analysis and discussion of risk levels.

The risk levels associated with these research-related legal requirements vary, depending on the compliance "standard," as reflected in the underlying law or regulation. This may sound straightforward. The author is continually reminded, however, in formal and informal settings, that many well-intentioned medical professionals and scientists (some new to the laws and customs of the United States) are only vaguely aware of their personal responsibilities for the "compliant" conduct of their research and clinical trials. The scope of activities for which principal investigators may be held responsible can be extensive.

Conclusion

By way of comparison, some observers view compliance as mostly a reactive activity that is supposed to fix things when they break, or shortly thereafter. Of course, this view begs the question: How does one know that something is broken? That determination depends, in part, upon the thoroughness of compliance investigations and related follow-up. More importantly, if a compliance officer and his or her "collaborators," such as high level executives, have dedicated sound thought and discussion of applicable compliance legal standards in a particular situation, things may not be as "broken" as some within an organization might suggest.

Sound analysis and discussion of possible compliance risks and proactive measures implemented as part of an effective compliance program should greatly reduce the tendency to assume that serious compliance infractions have occurred. Also, the points suggested in this article for considering compliance legal standards should help in workforce education and training and, in turn, on-the-job performance in many areas. A recommendation for ingraining this view in the culture of an organization is to refer to and act upon this statement from the OIG Model Voluntary Compliance Guidance for Hospitals: "Ultimately, compliance should become a routine part of hospital operations." This excerpt implies that certain compliance legal standards also are embedded, to some extent, in employees' routine work, particularly when that work involves the delivery of health care services and steps related to the creation or submission of claims for payment for those services.

"[T]he architecture of the compliance program must support delegated accountability and delegated responsibility across the workforce. This is essential if the organization is to have a meaningful chance to avoid or successfully defend against False Claims Act allegations or other enforcement authority."

Along these lines, the author often relies on these common sense expressions to drive home the importance to the workforce of proactively thinking about compliance legal standards; that is, forewarned is forearmed. Litigation is expensive, unpredictable, and best avoided. Compliance requires delegated accountability across an organization.

That last phrase, "delegated accountability," relates directly to the main theme of this article. Applicable compliance legal standards clearly must be understood by the compliance officer. Thereafter, the architecture of the compliance program must support delegated accountability and delegated responsibility across the workforce. This is essential if the organization is to have a meaningful chance to avoid or successfully defend against False Claims Act allegations or other enforcement authority. In general, to support an allegation of fraud, the relevant authorities require proof of "reckless disregard" of the truth or falsity of what is submitted to support a claim for payment. The suggestions in this article regarding organizational awareness and understanding of compliance legal standards, as well as concerted efforts to educate appropriate personnel about those standards, can help deflect allegations that the organization and its personnel are "recklessly disregarding" applicable laws and regulations.

The key task for compliance professionals is to strive to communicate clearly to others the applicable compliance legal standards that the organization should be attempting, in good faith, to meet through its compliance program. ■

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to go back five years for these individuals. Organizations will have to include officers, directors, and key employees of disregarded entities, however, if they have power or influence over a discrete segment or activity, assets, income, or expense.

The 2008 Form 990 includes a new schedule, Schedule J, Compensation. The schedule is completed by organizations that pay more than $150,000 of reportable compensation, $250,000 total compensation to at least one individual, or compensation paid to FODKEs. "[The] IRS believes that less than five percent of all taxpayers will have to file Schedule J," Hellums noted. Referring to the revamped and revised compensation reporting requirements, she said, "I think they hit us hard and heavy."

"We can't overemphasize the fact that the IRS wants total transparency for exempt organizations. The bottom line is that the IRS wants to see it all – 'The Full Monty,'" she added.

Hellums listed some best practices for organizations to follow due to increased scrutiny of exempt organization executive compensation:

- educate the board or subcommittee;
- assess governance practices, such as a conflict of interest policy;
- identify disqualified persons;
- conduct regular total compensation reviews;
- compile documentation as the basis for compensation decisions (comparability, independent/objective third party); and
- prepare minutes.

Reporting requirements for alternative investments. Exempt organizations increasingly have invested in alternative investments because of the promise that these vehicles will provide a high rate of return. Kurtzman noted, however, that "[j]ust because auditors list something as 'alternative investments' doesn't necessarily mean you have additional filings."

The best place to find out what you need to file is in the tax section of the investment's prospectus, she advised. "It is your fiduciary duty to know what you're investing in. The section has a wealth of information."

Kurtzman listed reasons a nonprofit would have foreign filings:

- investment in a foreign partnership (*e.g.*, direct investments, sending cash overseas);
- investments in a U.S. partnership that invests in a foreign corporation or partnership; and
- investment in foreign corporations, such as blockers or captive insurance companies.

FIN 48. "The IRS is very focused on reviewing the disclosures required by FIN 48," according to Bob Waitkus of the Cleveland Clinic Foundation. FIN 48, Accounting for Uncertainty in Income Taxes, applies to all tax income positions, including a tax-exempt organization's overall exempt status. Other FIN 48 areas of concern to exempt organizations include intermediate sanctions, unrelated business income, interest on intercompany loans, Internal Revenue Code §482 transfer pricing, and conversion of an organization from taxable to tax-exempt. "If you haven't begun to plan for implementing it, you need to start yesterday," Waitkus said. Tery Kennedy, Ernst & Young, Cleveland, Ohio, agreed. "Plan for implementation sooner rather than later."

Unrelated business income. In a session on allocating indirect or shared costs in connection with unrelated business income, Felicia Tucker, Ernst & Young, Long Island, New York, said that to prevent a tax-exempt organization from being afforded an unfair advantage over a taxable business, the IRS will carefully scrutinize the allocation base and methodology used. Tucker added that there is an increased IRS focus on exempt organizations and intercompany transactions with respect to allocation activity. She explained that expenses must be allocated on a reasonable basis. Reiterating a common theme in the conference, she stressed that "documentation is key."

Examples of reasonable allocation methods include hours spent and square footage. "A lot of times a gross receipts method is used as the default method, but it may not be the most reasonable method," Tucker noted, adding that when using an allocation methodology, it is important to use a consistent method.

Net operating losses (NOL) may be challenged by the IRS if there is an activity that consistently produces losses. Moreover, FIN 48 needs to be considered, specifically the amount of a deductible expense when allocation is applied. Therefore, the NOL should be the result of a "more likely than not" tax position. Tucker also warned attendees to properly substantiate all NOLs. "We have horror stories because NOLs could not be used because of lack of documentation," she said.

Electronic health records. In May, the IRS released a directive explaining that it will not treat the benefits that a hospital provides to its medical staff physicians as impermissible private benefit or inurement in violation of Internal Revenue Code §501(c)(3) if the benefit falls within the range of health information technology items and services allowed by HHS' electronic health record (EHR) regulations, and the hospital operates in accordance with the conditions set forth in the IRS directive.

Although the administrative branch of the federal government is firmly behind the use of EHRs,and the government has relaxed the Stark and anti-kickback rules to allow EHRs, the directive does not address whether any payment from a subsidized physician constitutes unrelated business income or the income tax consequences when a subsidy is provided to a physician, Howard Levenson, Ernst & Young, Washington, D.C. stated.

Joint ventures. Levenson said that when looking at the tax consequences of joint ventures, "control" seems to be a key in the authority that exists. He thinks that it is unlikely in today's economy that many private letter rulings will be issued on joint ventures.

"Institutions can't wait one year or longer to act on a deal," Levenson said. "The IRS is taking a long time for complex transactions, which include joint ventures. So we're left with the authorities that currently exist. Keep in mind that the IRS has the benefit of, and will use, hindsight to examine actual operations." ■

The Ernst & Young LLP 17th Annual Health Sciences Tax Conference , December 3-5, 2007.

Medicare

Traditional Medicare is more efficient than MA, MedPAC chair says

The Medicare Payment Advisory Commission (MedPAC) is continuing its call for lower Medicare Advantage (MA) payments, which it currently projects to be 13 percent higher than fee-for-service (FFS) payments. "These added expenditures contribute to the worsening long-range financial sustainability of the Medicare program," said MedPAC Chairman Glenn Hackbarth at a March 11, 2008, hearing of the House Ways and Means Health Subcommittee on MedPAC's annual March report.

MedPAC continues to support financial neutrality between payment rates for the fee-for-service program and the MA program, Hackbarth said. He noted that overpayments are 17 percent for private FFS plans and added that enrollment in these plans has more than doubled in the last year. "Neutrality is important to spur efficiency and innovation," he said.

Hackbarth added that MA plans, on average, "are less efficient than the traditional Medicare program." He emphasized, however, that FFS Medicare is not an efficient delivery system in most markets and that MedPAC has recommended ways to improve Medicare that would help the program coordinate care and select efficient providers.

Ranking subcommittee member Dave Camp (R-Mich.) called for expedient and significant reform of the Medicare program overall, noting that the Medicare Trustees estimate that the hospital trust fund will go bankrupt in 2019. Subcommittee Chairman Pete Stark (D-Calif.) supports eliminating the overpayments.

Although Camp said he does not oppose some reform of MA, he cautioned that if Congress were to cut more than $150 billion from the program, as MedPAC recommends, that would leave 22 states "without a single senior enrolled in Medicare Advantage." ■

CCH Washington Bureau, March 11, 2008.

In the News

Hospitals sue to block Medicaid regulation

The American Hospital Association and other hospital associations have filed a lawsuit to block implementation of a proposed Medicaid regulation that would cut $5 billion in funding to safety net hospitals, saying the regulation will make it harder to provide care for the uninsured. The hospitals specifically opposed the rule that would restrict federal Medicaid payments so that they do not exceed the cost of providing care. Congress last year put in place a moratorium that prevents CMS from issuing a final rule, but the moratorium is set to expire on May 25, 2008. The suit, filed in the U.S. District Court for the District of Columbia, argues that: (1) CMS has overstepped its authority; (2) Congress has barred the agency from imposing a cost limit on Medicaid payments to governmental providers; and (3) CMS improperly issued the rule on the very day (May 25, 2007) that the moratorium on the rule took effect.

CCH Washington Bureau, March 12, 2008.

Former health department commissioner sentenced

The former acting commissioner of the Virgin Islands Department of Health, Dr. Lucien A. Moolenaar II, DDS, has been found guilty of stealing government funds, grand larceny, and making false statements. Dr. Moolenaar was sentenced on March 17, 2008, to 15 months in prison followed by two years probation, three years of supervised release, and a $30,883 fine. The conviction stems from allegations that, in January 1995, Dr. Moolenaar found two old government payroll checks totaling $1,626 that had not been negotiated. After submitting the stale-dated checks to the Department of Finance for reissuance, the government added $1,626 to Dr. Moolenaar's June 22, 1995, net payroll as a negative deduction. Thereafter, from July 1995 through September 2000, due to human or computer error, the government added $1,626 to the second payroll check Dr. Moolenaar received every month. In the end, Dr. Moolenaar received and spent for his own benefit $102,497. When interviewed by officials from the Virgin Islands Office of Inspector General and Office of the Attorney General investigating the overpayments, Dr. Moolenaar falsely stated that he had no knowledge of the monthly overpayments until after they were discontinued.

DOJ News Release, March 17, 2008.

Lab company settles whistleblower suit for $461,000

A laboratory services company and its owner/president have agreed to settle allegations that the company submitted false claims for payment to Medicare in violation of the False Claims Act. "It is the American taxpayer who is victimized when a provider submits false claims to Medicare," said acting Assistant Attorney General Jeffrey S. Bucholtz. "Today's settlement demonstrates that the government has no tolerance for such misconduct and will diligently pursue providers who refuse to play by the rules." The Sarasota, Florida-based company has agreed to pay $461,000 to settle the *qui tam* action alleging that, at the direction of the company's owner, it submitted claims to Medicare for laboratory services that were not ordered, were not provided, were not medically necessary, or were improperly unbundled.

DOJ News Release, March 17, 2008.