CCH Health Care Compliance LETTER

Volume 12, Issue 11 health.cch.com June 2, 2009

Senate Committee releases health care reform policy options

The third and final round of policy options for financing reform of America's health care system have been released by the Senate Finance Committee Chairman Max Baucus (D-Mont.) and Ranking Member Charles Grassley (R-Iowa). The policy options are designed to reduce costs in the health care delivery system and expand quality, affordable health care coverage. The financing sources explored are (1) savings achieved from within the health care system from reductions in current levels of spending, (2) reevaluating current health tax subsidies, and (3) changing nonhealth tax provisions.

The Obama Administration has proposed a number of revenue raising measures to fund health care reform. All of the Administration's proposals are represented in the Senate policy options.

Health system savings. The Committee is examining the current health care system for opportunities to reduce waste and inefficiencies and produce savings necessary to finance health care reforms. Options for reducing costs with the current health care system include:

- *Ensuring appropriate Medicare and Medicaid payments*. Policy options include: (1) updating payment rates for home health services to be more reflective of actual costs of providing care; (2) ensuring appropriate payments for durable medical equipment such as oxygen and power wheelchairs; (3) adjusting payments for high-growth, potentially overvalued services such as imaging and minor procedures; (4) reducing "market basket" updates for providers whose payments are higher than actual costs; and (5) increasing and expanding the rebates paid by drug manufacturers to state Medicaid programs.
- *Capturing productivity gains*. The policy options look at three ways to adjust the annual inflationary increase to account for productivity in Medicare payment rate updates: (1) reduce the inflationary update by an amount equal to all of the expected productivity gains, (2) reduce the update by an amount equal to one half the expected productivity gains, or (3) reduce the update by an amount equal to one quarter of the expected productivity gains.
- *Reducing geographic variation*. Health care spending varies widely across the country and higher health care spending does not correspond to better quality care of care. The policy options explore ways to reduce geographic spending variation by reducing Medicare payments in areas where spending is above the national average. Adjustments would be made to reflect differences in input prices and beneficiary health status.
- *Making beneficiary contributions more predictable*. The policy options look at ways to make out-of-pocket cost-sharing more predictable and consistent with proposals to im-

continued on page 2

Wolters Kluwer Law & Business

prove the quality of care. For example, changing cost sharing in Medicare to apply a single deductible and copayments when there is none today, instituting nominal cost sharing in private Medigap policies, or capping total out-of-pocket cost sharing in Medicare or Medigap, or a combination of these.

Exploring current health care tax expenditures. Several options for modifying the current tax treatment of health-related expenses to eliminate inconsistencies and discourage wasteful health care spending are explored:

- *Exclusion for employer-provided health insurance*. Currently, employer-provided health insurance is not counted as income for tax purposes and the amount of health care benefits that are counted as tax free is unlimited. The policy options explore five changes to make the exclusion more equitable and efficient, including: (1) capping the exclusion based on the value of health insurance policy, (2) capping the income level of the employee eligible for the exclusion, (3) capping the exclusion based on both the value of the health insurance policy and income level, and (4) converting the employer-provided health insurance exclusion to an individual tax deduction or credit.
- *Modify health savings accounts (HSAs)*. Individuals enrolled in high-deductible health insurance plans can set up HSAs to withdraw for qualified medical expenses without paying taxes. Three ways to modify HSAs are being explored: (1) restricting HSA contributions to the lesser of the individual's deductible or the statutory limit, (2) increasing the penalty for withdrawing from an HSA for nonmedical expenses from 10 percent to 20 percent, and (3) requiring certification from the employer or from an independent third party that HSA withdrawals were made for medical expenses.
- *Modify or eliminate flexible spending accounts (FSAs)*. FSAs allow individuals and their employers to contribute an unlimited amount of tax free income to a Flexible Spending Account. The policy options explore limiting the amount that can be contributed to an FSA or eliminating FSAs altogether.
- *Standardize the definition of qualified medical expenses*. The policy option would apply a standard definition of qualified medical expenses for FSAs, HSAs, or itemized medical expense tax deductions.
- *Modify the itemized deduction for medical expenses*. The policy options examine elimination of the itemized deduction for medical expenses or raising the seven and a half percent floor for claiming deductions.
- *Modify the special deduction for nonprofit BlueCross BlueShield and similar organizations*. The policy options look to either reduce the special tax deduction from 25 to 10 percent or eliminate the deduction and unearned premium exclusion altogether.
- *Modify the FICA tax exemption for students*. The policy option would formally adopt the Internal Revenue Service (IRS) regulation narrowing the definition of school for purpose of the Federal Insurance Contributions Act (FICA) tax exemption for student employment.
- *Medicare payroll tax for state and local government employees*. The policy option would extend the Medicare payroll tax to all state and local government employees.
- *Modify the rules pertaining to nonprofit hospitals*. Nonprofit hospitals would be required to maintain a minimal level of charitable activity, limit charges to uninsured, indigent patients, and limit aggressive collection actions or be subject to an excise tax.

Lifestyle tax proposals. Two proposals to promote wellness and healthy choices, and curb activities that increase overall health care costs are proposed.

- *Increase taxes on alcoholic beverages*. The policies present the option of standardizing the tax on alcohol and would increase the excise tax from $13.50 per proof gallon to $16 per proof gallon.
- *Impose an excise tax on sugar-sweetened beverages*. A federal tax would be imposed on beverages sweetened with sugar, high-fructose corn syrup, or other similar sweeteners. The tax would not apply to artificially sweetened beverages. ■

Financing Comprehensive Health Care Reform: Proposed Health System Savings and Revenue Options, Senate Finance Committee, May 20, 2009

Community benefit standard under scrutiny for nonprofit hospitals

The community benefit standard required for hospitals to be tax-exempt is under increasing scrutiny, practitioners and an Internal Revenue Service (IRS) official recently reconfirmed. The standard, laid out in IRS Revenue Ruling 69-545, has remained virtually unchanged since 1969, Gwen Spencer of PricewaterhouseCoopers LLP in Boston commented, but a recent IRS report on nonprofit hospitals has focused a spotlight on the standard.

Spencer and others spoke at a program of the American Bar Association's Center for Continuing Legal Education that focused on the IRS hospital report. The program was moderated by Laura Gabrysch of Fulbright & Jaworski LLP in San Antonio.

Spencer noted recent comments by then IRS Exempt Organizations Commissioner Steven Miller that the standard may need to be refined and updated. IRS official Nikole Flax, a program participant, indicated that the report was motivated by a number of concerns: (1) determining how hospitals define and report community benefit; (2) the lack of a standard for community benefit and the lack of uniformity; and (3) determining how to distinguish nonprofit and for-profit hospitals.

Even though the IRS has these concerns, Flax noted that the report does not take a position on whether to revise or retain the community benefit standard. In conducting its study, the IRS sent questionnaires to over 500 nonprofit hospitals, but it did not audit any of the hospitals to determine whether they should retain tax-exempt status, Flax said.

Currently, hospitals have discretion in how they define and report community benefit, Flax said. They can choose whether to report the amount of uncompensated care based on costs or amounts billed (the IRS will require the use of costs on the revised Form 990 reporting for hospitals). The IRS did not attempt to verify the responses to the questions. Flax pointed out that the responses are based only on operations for 2005 and may not be representative.

Report's findings. Despite these possible shortcomings, Flax said the report provides "useful, interesting, and worthwhile findings." She indicated that the study reported great variations in the quantity and types of community benefit provided by nonprofit hospitals. There are multiple reasons for these variations, she said. If the community benefit standard were revised, the revision would affect hospitals differently. If a bright line is laid out, many hospitals could be in jeopardy of losing their exemption.

Flax reported that the average gross revenue for the 485 hospitals responding to the IRS survey was $179 million, although 21 percent of the hospitals ran a deficit. The average community benefit provided was an average of nine percent of revenues, with a median of six percent of revenues. Twenty-one percent of the hospitals reported that they provided community benefit below two percent of revenues.

Fourteen percent of the hospitals provided 63 percent of total uncompensated care. Fifteen hospitals conducted over 90 percent of the medical research. The largest component of community benefit was uncompensated care, at 56 percent. Other components of community benefit were education and training (23 percent), research (15 percent), and community programs (six percent). The percentage of uncompensated care rose as hospital revenues increased and as the size of the surrounding community increased.

Richard Frazier of Saul Ewing LLP, Philadelphia, asked Flax whether there was anything surprising or perhaps illogical in the report. Flax replied that the concentration of community benefit expenditures in a few hospitals was surprising to her. She noted that a small number or percentage of hospitals performed substantial spending on community benefit and its components, such as uncompensated care and research.

Flax also said that there are no other IRS projects on community benefit, but the Service will continue to assess the report data and until the release of the Form 990 data, which will not be available for a couple of years. Gabrysch asked whether the IRS is planning a "do-over" of the report, using information reported on the Form 990. Flax said she is not aware of any plans to do this, but that the IRS will use Schedule H information to continue assessing where the Service should focus.

Compensation study. The second portion of the hospital report concerned executive compensation practices. For hospitals responding to the survey, Flax reported that the average and median compensation of the chief executive were $490,000 and $377,000, respectively. For

continued on page 6

Federal Funding and Regulation of Health Care Information Technology and Electronic Health Records under the HITECH Act

by Michael A. Dowell, Esq.

The HITECH Act sets forth a framework for federal policy and the use of stimulus funds to promote the design, development, and operation of a nationwide health information technology and electronic health record (EHR) infrastructure that allows for the electronic use and exchange of information. The Act provides incentives under Medicare and Medicaid for hospitals and physicians that have EHR systems in place. To obtain incentives, providers must demonstrate "meaningful use" of EHRs through the adoption of "qualified" EHRs and the use of "certified" EHR technology.

The HITECH Act provides incentives under either Medicare or Medicaid for hospitals and physicians who have adopted electronic health records (EHR) systems determined to meet the Secretary's relevant guidance and statutory requirements for meaningful use: those providers can receive bonus payments starting in 2011. "Meaningful use" of an EHR includes three key components:

- the EHR must be certified and include ePrescribing capabilities;
- the technology must provide for the electronic exchange of personal health information with other systems (interoperability); and
- the system must produce reports utilizing various (yet to be defined) clinical and quality metrics.

The HITECH Act, has set aside $17 billion for incentive payments to providers who implement a qualifying EHR under either Medicare or Medicaid. Providers may only seek incentive payments under either Medicare or Medicaid but not both. Individual providers who are hospital-based" are not eligible for the incentive payments, because hospital-based providers will be encouraged to utilize the hospital's EHR. The Act defines "hospital-based professionals" to include pathologists, anesthesiologists, and emergency physicians who furnish substantially all of her or his services in a hospital setting (either inpatient or outpatient). Hospitals are entitled to a separate set of incentive payments under the law. Whether an eligible professional is hospital-based is determined by the billing or employment arrangements between the provider and the hospital.

Certified EHR technology is defined to include EHRs that have been deemed qualified in accordance with the necessary standards and implementation specifications as established under the Act. The National Coordinator is tasked with the development of qualified electronic health record technology (i.e. a certification system) for EHRs. The criteria for certification are to be developed under Section 3001 (c)(3) of the Act.

Medicare Incentive Payments to Physicians

Medicare incentives for physicians reimburse physicians that have EHR systems in place. Physicians who receive Medicare fee-for-service payments are eligible for this incentive program. The law excludes from the definition of eligible professionals physicians that are hospital-based such as radiologists, emergency medicine physicians, anesthesiologists and pathologists. Payments under the HITECH Act for physicians seeking Medicare incentives are all the same flat amount based on the year in which the provider places in service a qualifying EHR. No incentive payments will be provided before 2011 and after 2016.

Payout	2011	2012	2013	2014
2011	$18,000			
2012	$12,000	$18,000		
2013	$8,000	$12,000	$15,000	
2014	$4,000	$8,000	$12,000	$15,000
2015	$2,000	$4,000	$8, 000	$12,000
2016		$2,000	$4,000	$8,000
Total	$44,000	$44,000	$39,000	$35,000

Incentive payments will be increased by 10 percent if the physician predominantly serves beneficiaries in any area designated as a health professional shortage area ("HPSA").

For Medicare covered services that are provided during 2015 or thereafter by a physician that has not demonstrated meaningful usage of EHR technology, the Medicare physician fee schedule will be reduced as 1 percent for 2015, 2 percent for 2016 and 3 percent for 2017. Physicians that can demonstrate that there is a significant hardship can apply for a hardship exception, but that exception will only apply for a maximum of five years.

Medicare Incentive Payments for Hospitals

Beginning in 2011, incentive payments are available for "eligible hospitals" that are making meaningful use of an EHR and that submit quality metrics based on criteria identified by HHS. Hospital payments are based on a $2 million base amount.

Added to the base amount is an additional discharge-related payment. The sum of the base amount and the discharge related payment are multiplied by the hospital's Medicare share and a Transition Factor. Incentive amounts are phased out beginning in 2015 for hospitals that have not implemented a meaningful EHR. In addition, incentive payments are not available for hospitals that are not "meaningful EHR users."

1. Calculating the discharge amount: The per discharge amount is calculated by summing the total discharges beginning with the 1,500th discharge through the 23,000th discharge. The sum of discharges above 1,149 but below 23,001 for the hospital is then multiplied by $200.

2. Calculating the Medicare share: The Medicare share is calculated by summing the number of inpatient-bed-days attributable to individuals for whom payment is made under Medicare Part A and under a Medicare Advantage plan. (In the absence of Medicare specific inÂ¬patient data this amount is assumed to be zero.) This sum is then divided by the product of:

- the total number of inpatient-bed-days for the hospital during the 12-month period; and
- the total amount of eligible hospital charges during the period (excluding charges that are attributable to charity care) divided by total amount of the hospital's charges during the same period.

Hospitals that first qualify for the incentive payments after 2013 would receive incentive payments on a phased transition schedule. After 2015 no incentive payments will be paid and beginning in 2015 penalties will start to be imposed in the form of a reduction in Medicare payments.

Medicaid Incentive Payments for Physicians

Medicaid incentive payments are available for physicians and other providers ("health care professionals") who are acquiring EHR systems or updating existing systems. Health care professionals include physicians, dentists, physician assistants, nurse practitioners. To qualify, the health care professional must meet one of the following eligibility requirements:

- is not hospital-based and his or her practice consists of at least 30 percent Medicaid patients by volume;
- is not hospital-based, is a pediatrician and his or her practice consists of at least 20 percent Medicaid patients by volume; or
- a health care professional practices predominantly in a federally qualified health center or rural health clinic and has at least 30 percent of the health care professional's patient volume (as estimated in accordance with a methodology established by the Secretary) attributable to needy individuals.

Health care professionals are eligible for reimbursement of 85 percent of allowable EHR costs, not to exceed a maximum (per provider) of $65,000 over five years. Incentives are calculated through a formula that factors in the exact Medicaid mix seen by the provider. Health care professionals can get as much as $25,000 in the first year from Medicaid incentive payments to defray some of the cost of acquiring the technology, and earn up to $10,000 annually for four additional years to support "meaningful use" of EHRs.

Medicaid Incentive Payments for Hospitals

Hospitals with at least 10 percent Medicaid patient volume are eligible for an incentive payment based on a formula similar to the calculation for incentive payments provided for under the Medicare economic incentive, except that the numerator amount that is equal to the number of inpatient-bed-days includes days attributable to individuals who are receiving medical assistance. A hospital is eligible for Medicaid incentive payments in the first year that it demonstrates it has engaged in efforts to adopt, implement or upgrade EHR technology. Hospitals must have a qualifying EHR in place by 2016 to receive any Medicaid incentive funding. Hospitals can recoup up to 100 percent of "allowable" costs for an EHR through Medicaid incentive payments. Reimbursement is capped at 50 percent of actual costs for the first year and 90 percent for the first two years combined. Allowable costs are adjusted to reflect the Medicaid load for the provider.

Requirements to Adopt "Qualified" and "Certified" EHR

Providers must adopt qualified EHR to be eligible for HITECH payment incentives. Qualified EHR includes patient demographic and clinical health information such as medical history and problem lists and has the capacity to provide clinical decision support; support physician order entry; capture and query information relevant to health care quality; and exchanges electronic health information with and integrates such information from other sources.

"Certified EHR technology" means a qualified EHR that is certified as meeting standards pursuant to the HITECH Act. The Act created an HIT Standards Committee that will develop or recognize standards and certification criteria for recommendation to the ONC for endorsement and adoption by the HHS Secretary via regulation. The HHS Secretary will issue an initial set of standards, implementation specifications. and certification requirements by December 31. 2009. These standards, specifications, and requirements will play an important role in determining the certification requirements for certified EHRs.

Requirements to Demonstrate "Meaningful Use" of EHR

To be eligible for incentive payments the eligible hospital or physician must demonstrate meaningful use through compliance with the following requirements:

- demonstrate that the provider or health care professional is using certified EHR technology in a meaningful manner, which include electronic prescribings;

On The Front Lines (cont.)

- demonstrate that the certified EHR technology is connected in a manner that allows for the electronic exchange of health information to improve the quality of health care consistent with the criteria set forth in the Act; and
- submit information on clinical quality measures and other measure in a form and manner as specified by the Secretary of HHS in later communications or guidance.

HHS will specify in future rules or regulations additional guidance on how a provider can demonstrate that it is a meaningful user. Options may include an attestation, the submission of claims with specific coding indicating that the patient encounter was documented using an EHR, a survey response, or through a reporting mechanism. HHS also will post on the CMS website a list of the names of those hospitals that are meaningful EHR users.

Conclusion

The HITECH Act sets forth a framework for the development of federal policy and expenditure of federal stimulus money to advance the design, development, and operation of a nationwide health information technology and EHR infrastructure that allows for the electronic use and exchange of health information. Providers should immediately review their internal operations, budgets, and contracts as a first step toward becoming EHR ready. Health care organizations acquiring or updating EHR systems should consult with competent health care law counsel on the legal requirements applicable to their operations. It is also important to obtain vendor contractual commitments that they are certified and will meet the requirements of certification panels and will permit usage in accordance with the federal definition of "meaningful use."

Michael A. Dowell, Esq., a partner and Co-Chair of the Health Care Industry Group in the Los Angeles office of the law firm of Theodora Oringher Miller & Richman. Mr. Dowell counsels hospitals and health systems, health plans, insurers, governmental entities, physician organizations and personal health record vendors with respect to a wide range of privacy and security compliance issues. He has written and lectured extensively on HIPAA privacy and security, security breach notification issues, and state and federal privacy and security laws. Mr. Dowell can be contacted at mdowell@tocounsel.com.

Tax-Exempt Organizations (cont.)

20 hospitals that were audited, however, the average and median compensation was $1.4 million and $1.3 million, respectively.

The IRS wants more information on compensation practices, Flax said, but it does not have a specific concern on this subject. The current university study and other future compliance studies will have an executive compensation component. The IRS also will look at for-profit comparables and is interested in organizations that pay above-average salaries, she indicated.

Ralph DeJong of McDermott, Will & Emery LLP in Chicago said it is interesting what the study asked and did not ask. The IRS did not ask whether organizations took "all" required steps to satisfy the rebuttable presumption for reasonable compensation; whether organizations used comparables from other organizations with comparable revenues; and what it meant for an organization to set compensation within the range of comparable data.

DeJong said the study demonstrates that organizations were "serious" about using the rebuttable presumption, but he was surprised to see that 10-20 percent of the organizations did not do this. He also questioned whether the study measured amounts based on a consistent definition of compensation. For example, some organizations may have failed to include retirement contributions or may have included retirement payouts.

The survey asked about business dealings between an organization and its officials and board members. DeJong said the study would have been more helpful if it had focused on transactions involving members of the board's compensation committee, which could affect its impartiality in setting compensation levels. He noted that many organizations find board members through their business dealings, but this does not mean that the organization is seeking to do business with members after they join the board. ■

CCH Washington Bureau, May 18, 2009, reprinted from the CCH Exempt Organizations Reports, Issue No. 418

Anti-Kickback/Physician Self-Referral

OIG OKs charitable assistance for advanced diagnostic tests

A nonprofit, tax-exempt, charitable organization's proposed arrangement that would provide financial assistance with cost-sharing obligations associated with certain advanced diagnostic testing owed by financially needy patients, including Medicare and Medicaid beneficiaries, would not result in the imposition of civil money penalties or administrative sanctions under the anti-kickback statute, according to the Office of Inspector General (OIG).

Background. The patient assistance program provides financial assistance to financially needy patients who are HIV-positive or have colorectal cancer and require certain costly diagnostic tests related to their medical care.

Analysis. Two aspects of the arrangement require scrutiny: (1) the donor contributions to the organization, and (2) the organization's grants to the patients. Long-standing OIG guidance makes it clear that industry stakeholders can effectively contribute to the health care safety net for financially needy Medicare and Medicaid patients by contributing to independent, *bona fide* charitable assistance programs. Under a properly structured program, such donations should raise few, if any, concerns about improper beneficiary inducements.

Donor contributions. The design and administration of the arrangement places an independent, *bona fide* charitable organization between donors and patients in a manner that effectively insulates ben-

eficiary decision-making from information attributing the funding of their benefit to any donor. It is unlikely, therefore, that donor contributions influence any patient's selection of a particular provider, practitioner, supplier, service, or product. There also appears to be a minimal risk that donor contributions improperly influence referrals to any provider, practitioner, supplier, service, or product. OIG reached this conclusion based on the following:

- no donor or affiliate of any donor exerts direct or indirect control over the organization or its funds;
- assistance is awarded in a truly independent manner that severs any link between donors and beneficiaries;
- assistance is awarded without regard to any donor's interests and without regard to the applicant's choice of product, provider, practitioner, service, or supplier;
- assistance is provided based upon a reasonable, verifiable, and uniform measure of financial need that is applies in a consistent manner;
- donors are not provided with any data that allows them to correlate the amount or frequency of its donations with the amount or frequency of the use of its products or services; and
- although donors are permitted to earmark donations for the funds, the risk of abuse should not arise.

Grants to patients. The provision of assistance with cost-sharing obligations for certain eligible, financially needy beneficiaries is not likely to influence improperly any beneficiary's selection of a particular provider, practitioner, supplier, service, or product. OIG based its opinion on the following factors:

- all eligible, financially needy patients are assisted on a first-come, first-served basis, to the extent funding is available;
- the determination of an applicant's financial qualification for assistance is based solely on his or her financial need, without considering the identity of any of his or her health care providers, practitioners, suppliers, services, or products; the identity of any referring party; or the identity of any donor that may have contributed for the support of the funds or the amount of the donation;
- assistance in no way limits beneficiaries' freedom to select any testing supplier, regardless of whether the supplier has made contributions to organization; and
- the organization's own interest as a charitable, tax-exempt entity that must maximize use of its scarce resources to fulfill its charitable mission ensures that it has a significant incentive to monitor utilization so as to keep expenditures to a minimum.

Conclusion. The entity's position as an independent charitable organization between donors and patients and the design and administration of the arrangement provide sufficient insulation so that assistance to patients should not be attributed to any of its donors. Donors are not assured that the amount of financial assistance their patients, clients, or customers receive bears any relationship to the amount of their donations. Donors are not guaranteed that any of their patients, clients, or customers receive any financial assistance whatsoever. ■

OIG Advisory Opinion, No. 09-04, May 11, 2009, Health Care Compliance Letter, ¶500,208

Obama signs the Fraud Enforcement and Recovery Act

On May 20, 2009, President Obama signed the Fraud Enforcement and Recovery Act of 2009 (FERA) into law. According to the White House, the legislation (1) strengthens the capacity of federal prosecutors and regulators, and (2) provides the resources to keep markets free and fair.

FERA expands the Department of Justice's (DOJ) authority to prosecute crimes involving mortgage fraud, commodities fraud, and fraud involving U.S. government assistance provided during the recent economic crisis.

With regard to health care fraud, FERA amends the False Claims Act (FCA) to correct erroneous interpretations of the law which has allowed subcontractors and non-governmental entities to escape responsibility.

FCA implications. The effectiveness of the FCA has been recently undermined by court decisions limiting the scope of the law and allowing subcontractors and non-governmental entities to escape responsibility for proven frauds. FERA amends the FCA to correct these erroneous interpretations of the law that have required the government to prove that "a defendant must intend that the government itself pay the claim," for there to be a violation. Under this line of court decisions, therefore, even when a subcontractor in a large government contract knowingly submits a false claim to general contractor and gets paid with government funds, there can be no liability unless the subcontractor intended to defraud the federal government, not just their general contractor.

Similarly, a court has held that liability under the FCA can only attach if the claim is "presented to an officer or employee of the government." Referred to as the "presentment clause," the court interpreted this clause to limit recovery for frauds committed by a government contractor when the funds are expended by a government grantee to a subcontractor. FERA clarifies that liability under the FCA attaches whenever a person knowingly makes a false claim to obtain money or property, any part of which is provided by the government without regard to whether the wrongdoer deals directly with the federal government; with an agent acting on the government's behalf; or with a third party contractor, grantee, or other recipient of such money or property.

Medicaid implications. As some defendants have argued that these recent court decisions restrict FCA liability from attaching to Medicaid claims, FERA clarifies that the FCA reaches all false claims submitted to state administered Medicaid programs. By removing the offending language, which requires a false claim be presented to "an officer or employee of the government," the bill clarifies that direct presentment is not required for liability to attach.

White House Press Release and Fact Sheet, May 20, 2009

Fraud & Abuse

HHS/DOJ create interagency enforcement team

Attorney General Eric Holder and HHS Secretary Kathleen Sebelius have announced a new interagency effort, the Health Care Fraud Prevention and Enforcement Action Team (HEAT), to combat Medicare fraud. Holder and Sebelius also announced the expansion of Strike Force team operations to Detroit and Houston.

The HEAT team will include senior officials from DOJ and HHS who will build upon and strengthen existing programs and invest new resources and technology to prevent fraud, waste and abuse. Efforts will include the expansion of joint DOJ-HHS Medicare Fraud Strike Force teams that have been successfully fighting fraud in South Florida and Los Angeles.

The Strike Force team operating in South Florida has convicted 146 defendants and secured $186 million in criminal fines and civil recoveries. The Medicare Fraud Strike Force expanded in May 2008 to phase two in Los Angeles, where 37 defendants have been charged with criminal health care fraud offenses. In the Los Angeles cases, more than $55 million has been ordered in restitution to the Medicare program.

The HEAT team also will build on demonstration projects by the HHS Inspector General and CMS that focus on suppliers of durable medical equipment (DME). These projects increase site visits to potential suppliers to prevent imposters from posing as legitimate DME providers. Other initiatives include: (1) increasing training for providers on Medicare compliance; (2) improving data sharing between CMS and law enforcement so they can identify patterns that lead to fraud; and (3) strengthening program integrity activities to monitor and ensure Medicare Advantage plans and prescription drug programs compliance and enforcement. ■

Joint HHS and DOJ Press Release, May 20, 2009

In the News

AHA awarded HIT national survey grant

The Office of the National Coordinator (ONC) for Health Information Technology (HIT) announced the award of a grant to the American Hospital Association (AHA). The award will help fund the Association's national survey of hospitals measuring the adoption and use of electronic health records by these providers. The award amount is $101,973. The project period for the award is 12 months with the option of four additional years of funding at the same level. The ONC justified the award of the grant without competition because the AHA has many years of experience conducting surveys with a high response rate across all United States hospitals.

HHS Announcement, 74 FR 23407, May 19, 2009

CCHIT approves certification criteria

On May 19, 2009, the Certification Commission for Healthcare Information Technology (CCHIT®) announced its approval of final 2009-2010 criteria for certification of ambulatory, inpatient, and emergency department electronic health records (EHRs), and its new stand-alone electronic prescribing certification. CCHIT also approved updated criteria for the ambulatory add-on options in child health and cardiovascular medicine. On May 29, CCHIT will publish at www.cchit.org detailed criteria, test scripts, and a companion guide mapping the criteria to the characteristics of a qualified EHR, as described in the American Recovery and Reinvestment Act (ARRA). CCHIT plans to release the updated certification handbook and announce further details regarding application for 2009-2010 certifications during June or July.

CCHIT News Release, May 19, 2009

EMTALA action against CDT dismissed

Claims brought against a center for diagnosis and treatment (CDT) by the family of a patient who sought treatment at the CDT and died after discharge were dismissed because the CDT was not a "participating hospital" under the Emergency Medical Treatment and Active Labor Act (EMTALA). The family alleged that the CDT and the attending physicians did not furnish appropriate medical treatment to the patient who sought treatment for headache, sore throat, fever and diarrhea because the CDT discharged her with the diagnosis of tonsillitis or a cold without performing tests. The following day she lost consciousness and was returned to the CDT where she died. An autopsy determined that she died of Dengue Shock Syndrome. EMTALA states that a "hospital" provides medical services to inpatients, while Puerto Rico law states that CDTs provide medical services to ambulatory patients. Because CDTs do not provide medical services to inpatients, they are not a hospital as described under the law and, therefore, are not subject to EMTALA. With respect to the action against the individual physicians, it was determined previously that a private cause of action cannot be brought against physicians. Thus, the family has been ordered to show cause as to why the EMTALA claims against the individual physicians also should not be dismissed.

Rosa-Rodriquez v. Centro San Cristobal-Villalba, D. P.R., May 12, 2009, Health Care Compliance Reporter, ¶800,652