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On The Front Lines 4

Private enforcement: An update on HHS' enforcement of the HIPAA privacy rule by Leesa Klepper, J.D., Contributing Editor

Corporate Governance 1

- Research report identifies critical elements of ethical culture

Medicare 2

- Providers should prepare now for RAC expansion

Tax-Exempt Organizations 3

- IRS report on executive compensation belies concerns

Health Information Technology 7

- Move to EHR requires stakeholder buy-in, experts stress

In The News 8

Wolters Kluwer Law & Business

Research report identifies critical elements of ethical culture

by Pam Maloney, J.D., Contributing Editor

An ethical culture often has greater impact on achieving an effective ethics and compliance program than do program inputs and activities, according to a research report sponsored by the Ethics Resource Center (ERC) in partnership with WorkingValues™. The report builds upon ERC's 2005 National Business Ethics Survey (NBES).

The research report identified two key elements of an ethical culture: (1) of the 18 "Ethics Related Actions" (ERAs) that were measured in the NBES, three had the most impact on the successful outcome of an ethics and compliance program; and (2) formal ethics training does not have the same impact on all levels of employees.

In measuring the 18 dimensions of an ethical culture, the NBES defined a separate set of ERAs for each level of management, as well as for workers. There was an overlap in the ERAs at each level, especially in terms of setting a good example and establishing accountability. ERC concluded that employees who perceived their managers, supervisors, and coworkers as displaying ERAs were more likely to identify outcomes expected of an effective ethics and compliance program than those who observed fewer ERAs.

The report identified three ERAs as having the greatest impact on an organization's ethical culture: (1) setting a good example; (2) keeping promises and commitments; and (3) supporting others in adhering to ethics standards. Employees need to see their superiors and coworkers modeling ethical behavior in their daily work and decision-making processes. Organizations that commit substantial resources to the communication of ethical values may find that the resources are better spent helping to focus leadership's attention on the critical need to improve these ERAs, thereby giving the organization a better chance to achieve the ethics program's goals.

According to the report's second key finding, ethics training needs to be different for management and nonmanagement employees. Ethics training can be more useful in preparing junior employees to handle situations that leave them open for misconduct than it may be for senior employees. The report does not suggest that all ethics training be discontinued for top and mid-management employees, but rather that training programs be tailored to take these differences into account. For example, training for upper management can focus on how to engage in ERAs, while training geared for junior employees can include instructions on how to respond to ethics challenges. ■

CCH Chicago Bureau, May 1, 2007.

Providers should prepare now for RAC expansion

by Catherine Hubbard, M.A., Contributing Editor

Hospitals and physicians need to prepare now for the expansion of CMS' pilot project for recovering Medicare overpayments, Nancy Hirschl, president of Hirschl and Associates, Laguna Niguel, California, told attendees of a May 17, 2007, teleconference hosted by the Healthcare Financial Management Association. Recovery audit contractors (RACs) soon will be expanding their responsibilities from the three states currently involved in the project to all 50 states. Hirschl and Paul Belton, vice president of corporate compliance, Sharp HealthCare, San Diego, California, who have been dealing with the pilot project, outlined the program and suggested steps providers should take to avoid a dispute.

Historical and legislative background. The RAC pilot project was developed to identify improper Medicare payments not detected through existing error detection and prevention program efforts, Belton said. He noted that from 1996 to 2002, Medicare fee-for-service error rates reported by the Office of Inspector General (OIG) showed a "healthy increase" in net overpayments, from $13.3 billion in 2002 to $19.6 billion in 2003 and $19.8 billion in 2004.

Pursuant to the Medicare Modernization Act of 2003, HHS directed CMS to use RACs to investigate claims, identify overpayments and underpayments, and collect the overpayments so they may be returned to the Medicare Trust Fund, according to Belton. In March 2005, the three-year pilot program began in the states with the highest Medicare expenditures: California, Florida, and New York.

Hirschl noted that the Tax Relief and Health Care Act of 2006 made the RAC program permanent and mandated expansion of the program to all 50 states by no later than 2010. By 2010, CMS plans to have four RACs in place, she said. As part of the expansion process, one or two states will be added to the current three RAC jurisdictions this year, Hirschl added.

Medicare secondary payer RACs. Medicare secondary payer (MSP) RACs, which identify situations in which Medicare should not have been the primary payer, have found a total of $4 million in overpayments, according to Hirschl. The return on investment is 373 percent, with a benefit-to-cost ratio of $4.73 for every dollar, she said, adding, "It is easy to see why CMS is taking this program to all 50 states as soon as possible." Belton noted, "The RACs have been very successful."

Non-MSP RAC process. RAC claim reviews are automated and national claims data are scrubbed using proprietary data mining software, Belton said. Non-MSP RACs primarily review outpatient services. They also review claims and medical records to identify payment errors, diagnostic related group (DRG) errors, coding errors, noncovered services, medical necessity, duplicate claims, medically unlikely edits, and technical denials from complex medical reviews, he added. According to Belton, RAC claim reviews do not require medical record review.

The three RACs tend to emphasize different problems and focus on different DRGs, the speakers said. In California, for instance, the RAC has been denying claims due to the lack of patients meeting medical necessity criteria. Hirshl noted that California also has focused on inpatient hospital claims and, more recently, some durable medical equipment and physician claims, he added. In Florida, the primary focus has been physician claims, and in New York the primary focus has been hospital inpatient and outpatient claims, she said.

Preparing for RAC review. To prepare for the RACs, the speakers suggested that hospitals monitor the OIG Work Plan for the current year and know the target areas, which include DRG validation, medical necessity, discharge dispositions, transfer provision DRGs, one-day stays, and three-day stays in skilled nursing facilities.

The process for providers in the pilot states has proven burdensome because the providers must defend their payments, increase their billing tracking, and modify their billing practices, the speakers explained. To prepare for the expansion of RACs, the speakers advised that providers focus on:

- physician documentation improvement;
- coder education and training;
- DRG validation and benchmarking;
- health information management;
- charge assignment validation; and
- charge protocols.

continued on page 3

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Belton also suggested that hospitals and networks appoint a RAC committee and analyze how they are going to receive record requests. "You need to prepare for that," he said. For example, in a complex review, Belton cautioned, if a RAC requests medical records and does not receive hard copies of the records within 45 days, the RAC is authorized to find that the claim was overpaid. RACs should work with providers who require added time, Belton said. "You should ask for extensions if you have difficulty with that 45 day limit," he noted. The RAC team should consist of staff from health information management, compliance and revenue integrity, finance, medical staff, case management, business office, ancillary, and nursing staff, he said.

According to Belton, once the hospital is notified of a RAC decision, it has the right to appeal. He cautioned, however, that when a case is under appeal, interest is charged as the overpayment accrues and the hospital is obligated to pay the interest in addition to the overpayment if the appeal is denied. "That is somewhat alarming," he commented.

The potentially larger scale of overpayments, in terms of both the number of claims and total dollar value, that will result from RAC audits make it prudent for providers to review their practices in addressing government audits and claims of overpayment, Belton stated. Because of the larger amounts at stake, more resources may be needed in the early stages of the appeal process to develop the factual record that sets the foundation for the issues that can be appealed to federal court, he said.

"Medicare is getting very serious... about identifying claims that have been overpaid," said Hirschl, adding, "The intent is not to find underpayments.... That we need to do on our own." ■

CCH Washington Bureau, May 17, 2007.

Tax-Exempt Organizations

IRS report on executive compensation belies concerns

by George Jones, Contributing Editor

Despite front-page news stories and criticisms by the chairman and ranking member of the Senate Finance Committee regarding "creative" nonprofit executive compensation packages, the Internal Revenue Service's (IRS') February 2007 Report on Exempt Organizations Executive Compensation Compliance Project did not support "the horror stories about unreasonable comp[ensation]," according to David Fish, Manager of the IRS Exempt Organizations Technical Guidance and Quality Assurance office. The results of the IRS' compliance initiative were discussed in conjunction with a presentation of practical compliance tips for tax-exempt organizations reporting executive compensation, held by the Women's Bar Association of Washington, D.C., on May 30, 2007.

Reporting problems. The Compensation Project, which was based on a nonstatistical sample of more than 1,800 large and small exempt organizations, revealed that while "significant reporting errors exist," (more than 30 percent of 1,223 compliance check recipients needed to amend their Form 990) the examinations did not support the widespread, publicized concerns that tax-exempt organizations were creatively defining and reporting executive compensation. But where problems were found, significant taxes were assessed, said Fish. The Project revealed that excise tax examinations were initiated against more than 40 disqualified persons associated with 25 organizations, resulting in more than $21 million in assessments.

According to Fish, while smaller organizations seemed to be "sloppier" in their reporting, no generalizations could be made. Fish reiterated the Compensation Project's disclaimer that, in light of the nonstatistical sampling of organizations, "no definitive statement can yet be made about compliance levels in this area" and "[c]ontinued work in the area of executive compensation is warranted."

Compliance tips. Fish and Thomas Hyatt, chairman of the Ober/Kaler Nonprofits Group, offered practical compliance tips for nonprofits reporting executive

continued on page 8

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On The Front Lines

Private enforcement: An update on HHS' enforcement of the HIPAA privacy rule

by Leesa Klepper, J.D., Contributing Editor

As we mark the fourth anniversary of compliance with the minimum national standards to protect the privacy of personal health information – and at a time of intensified individual concern over privacy protections – it seems timely and important to review and analyze HHS' enforcement of the federal privacy standards issued under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) (referred to herein as "the Privacy Rule").[1] Coincidentally, on Friday, April 20, 2007, HHS launched a new website designed to provide health care entities and individuals with more information about compliance and enforcement of the Privacy Rule.[2]

Based on a review of the available data and a phone call with a senior advisor in the HHS Office of Civil Rights (OCR),[3] this article summarizes and analyzes HHS enforcement efforts. As described in further detail below, enforcement is still primarily complaint driven, and change has come through voluntary resolution and not yet through imposition of any penalties. HHS has been actively investigating thousands of health care entities for noncompliance with the Privacy Rule and has successfully obtained corrective action in over 4,000 cases, but there is still little information publicly available about the nature of such noncompliance and required corrective actions.

Privacy rule compliance and enforcement provisions

The Privacy Rule required covered entities, which are certain health care providers, health plans, and health care clearinghouses,[4] to comply with the privacy standards by April 14, 2003.[5] HIPAA authorized the HHS Secretary to enforce the privacy standards, and the Secretary delegated the administration and enforcement of the privacy standards to OCR.

The Privacy Rule sets forth detailed provisions regarding compliance and enforcement. Under the Rule, enforcement is essentially complaint driven, and the approach to compliance is through voluntary cooperation.[6] Any person who believes that an entity did not properly use or protect personal health information has the right, and is encouraged by HHS, to file a complaint within 180 days after discovery of a violation.[7] Under the Rule, HHS may investigate a complaint, including by review of the policies, procedures, or practices of a covered entity and the circumstances surrounding any alleged violation.[8] In addition, pursuant to a notice issued on April 16, 2007, OCR has the authority to issue subpoenas in investigations of alleged violations of the Privacy Rule.[9]

The Secretary also may initiate reviews to determine whether entities are complying with the privacy standards.[10] If an investigation indicates noncompliance, the Rule directs HHS first to attempt to reach a satisfactory resolution through informal means, which may include demonstrated compliance or a completed corrective action plan.[11] If the matter is not resolved by informal means, entities that are found to have violated the provisions of the Privacy Rule may be subject to both civil money penalties and criminal penalties.[12] OCR is responsible for enforcing the Privacy Rule with respect to voluntary compliance activities and civil money penalties, and the Department of Justice (DOJ) is responsible for enforcement of the HIPAA criminal provisions.

Complaints and OCR investigations from April 2003 to the present

Although the HHS Secretary is authorized to initiate a compliance review, almost all investigations have been incident driven, and enforcement has been primarily complaint driven.[13] According to the new HHS website and a recent OCR presentation, OCR has received 26,408 complaints from April 14, 2003, to March 31, 2007.[14] Of those complaints, 5,931 are currently under investigation and 20,477 have been "closed."[15] OCR deems complaints[16] closed if they are concluded after preliminary review or resolved after an investigation. Complaints may be closed after a preliminary review for a number of reasons, including: the patient failed to file a complaint within the required 180-day timeframe; the complaint was not filed against an entity required to comply with the Privacy Rule; the complainant failed to provide written consent to the investigation;[17] or the complaint failed to allege a violation of the Privacy Rule.[18] Once an investigation has been completed, OCR will close the case when it has concluded that no violation has occurred or when it successfully has obtained corrective action.

The complaint and investigation statistics to date are revealing as to both HHS' approach to enforcement and covered entities' vulnerabilities in compliance. First, the number of investigated cases has increased each year since the compliance date. From April to December 2003, only 339 cases were investigated and 1,169 cases were closed after preliminary review. In 2004, 1,392 cases were investigated and OCR obtained corrective action in 1,033 cases. In 2005, 1,803 cases were investigated and OCR obtained corrective action in 1,161 cases. In 2006, 2,466 cases were investigated and OCR obtained corrective action in 1,571 cases.[19] (*See* Table A). Meanwhile, the number of cases ineligible for investigation has decreased.[20] There are several possible reasons for this increase in investigated cases. One possibility is that, over time, more individual patients are aware of their rights under the Privacy Rule. Another possibility is that OCR is more focused on enforcement. According to a senior OCR advisor, the reason for the increase in investigated cases is mixed. She posited that OCR is now more efficient at processing complaints and has the resources to conduct more investigations.

Second, the recent data from OCR reveals that the vast majority of complaints (over 75 percent) are closed after preliminary review. Combined with those cases for which investigations found no violation, almost 80 percent of complaints resulted in no action.[21]

Third, and perhaps most important for health care entities concerned about compliance, in over 20 percent of complaints filed and 67 percent of all investigations, OCR has required corrective action and obtained voluntary compliance.[22] OCR has obtained voluntary compliance from over 4, 447 entities. OCR emphasizes that these statistics demonstrate that they have an "active enforcement program" designed to seek voluntary compliance and corrective action. As the Director of OCR, Winston Wilkinson, noted in the recent OCR web launch announcement, "HHS has obtained significant change in the privacy practices of covered entities through its enforcement program. Corrective actions obtained by HHS from these entities have resulted in change that is systemic and affects all the individuals they serve."[23] To date, all Privacy Rule investigations have been concluded to the satisfaction of OCR through voluntary resolution. These investigations and resolutions most certainly were time-consuming and demanding for the health care entities involved.

According to OCR, the majority of the entities found to have violated the Rule and required to institute corrective action have been, in order of frequency:

- private physician practices;
- general hospitals;
- outpatient facilities;
- pharmacies; and
- group health plans.[24]

A senior advisor at OCR was not able to provide a more detailed percentage breakdown or further details about these entities.

The new web site also lists five broad issues investigated most frequently:

- impermissible uses and disclosures of protected health information;
- lack of safeguards for protected health information;
- lack of patient access to their protected health information;
- uses or disclosures of more than the "minimum necessary" protected health information; and
- lack of or invalid authorizations for uses and disclosures of protected health information.[25]

HHS' new web site also provides nine case examples for which OCR obtained corrective action.[26] The examples could be useful educational tools for entities trying to identify areas of vulnerability and maintain compliance. For example, the only two case examples involving private practices involve a lack of patient access to personal health information. Several other case examples involve pharmacy chains or health plans and the failure to safeguard health information or properly use and disclose

Table A: OCR Enforcement Results

Year	Investigated Cases – Found No Violation	Investigated Cases – Obtained Corrective Action	Total Investigated Cases	Cases Concluded After Preliminary Review	Total Closed Cases
4/14/2003-12/31/2003	79	260	339	1,169	1,508
1/1/2004-12/31/2004	359	1,033	1,392	3,372	4,764
1/1/2005-12/31/2005	642	1,161	1,803	3,818	5,621
1/1/2006-12/31/2006	895	1,571	2,466	4,001	6,467

such information. For example, in one case, a grocery store-based pharmacy chain maintained pseudoephedrine log books containing protected health information in a way that individual health information was visible to the public at the pharmacy counter.[27] Among other mandatory actions, OCR required that the pharmacy chain implement national policies and procedures to safeguard the log books and train its staff on the revised policy.[28] Additional case examples would further enable health care entities to identify areas of risk and update their compliance plans.

Civil money penalties and criminal penalties

To date, OCR has never recommended that civil money penalties (CMPs) be imposed.[29] Of course, that does not mean that CMPs could not be imposed in the future, and, if a covered entity does not take satisfactory action to resolve findings of noncompliance, OCR may decide to impose CMPs. But OCR has been successful in obtaining compliance without CMPs, which seems to be a testament to OCR's efficient efforts to work with health care entities and the entities' genuine commitment to comply with the privacy standards.

Furthermore, while OCR has referred over 384 cases involving the knowing disclosure of protected health information to the DOJ for criminal investigation, to date, none of these cases has been prosecuted.[30] The DOJ has prosecuted only four cases involving HIPAA privacy violations, and all four involved employees of a covered entity selling protected health information for some personal financial gain.[31] Some have claimed that this lack of HIPAA prosecutions raises questions about the effectiveness of HIPAA enforcement and the DOJ's commitment to the prosecution of HIPAA violations.[32]

Implications for covered entities and their compliance plans

Until the launch of HHS' new web site, enforcement of the Privacy Rule seemed to be "private" — that is, there was little readily available public information about the number and nature of complaints, types of health care entities investigated, types of noncompliance identified, and required corrective action. While the launch of the new site is a welcome and needed resource, and OCR intends to make information about enforcement actions available on a regular basis,[33] the currently available information provides just a small glimpse into the types of entities that most frequently have been required to take corrective action and areas of noncompliance. The lack of public disclosure makes it difficult for health care entities to identify and correct areas of vulnerability and learn from others' creative corrective action. Additional and more detailed information, updated on a regular basis, would assist entities in identifying areas of vulnerability, managing risk, and avoiding common noncompliance issues.

Also, it is hard to truly assess the effectiveness of HHS' enforcement approach to the Privacy Rule given the paucity of detailed information about complaints, the nature of entities' noncompliance, and the corrective action required. The recent data suggests that, overall, the health care industry is working hard to be in compliance with the Privacy Rule's requirements and that OCR has been helpful in providing education and assistance. Enforcement through such informal means is surely more cost and time-efficient than litigation and also may prove to be most effective at securing the ultimate goal of successfully protecting patient privacy. ■

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1 45 C.F.R. §§160, 164.

2 *See* HHS, *HHS Launches New Web site on HIPAA Privacy Compliance and Enforcement*, April 20, 2007, *available at* http://www.dhhs.gov/ocr/privacy/enforcement/.

3 Telephone interview with OCR Senior Advisor and HHS Official, April 24, 2007 (*hereinafter* 4/24/07 Telephone Interview).

4 45 C.F.R. §164.104(a) (stating that provisions of the Privacy Rule apply to "health plans," "health care clearinghouses," and health care providers who transmit any health information in electronic form). These entities are known collectively as "covered entities." *Id.*

5 45 C.F.R. §§164.534(a)-(c) (ordering that covered entities, with the exception of "small health plans," as defined, were required to comply with the Privacy Rule provisions by April 14, 2003). Small health plans were required to be in compliance on April 14, 2004. *Id.*

6 45 C.F.R. §160.304.

7 45 C.F.R. §160.306. *See also* HHS, *Fact Sheet: Your Health Information Privacy Rights*, *available at* http://www.dhhs.gov/ocr/hipaa/consumer_rights.pdf; HHS, *Fact Sheet: Privacy and Your Health Information*, *available at* http://www.dhhs.gov/ocr/hipaa/consumer_summary.pdf; HHS, *Fact Sheet: How to File a Health Information Privacy Complaint with the Office for Civil Rights*, *available at* http://www.dhhs.gov/ocr/privacyhowtofile.htm.

8 46 C.F.R. §160.306(c).

9 *Notice*, 72 FR 18999-19000, April 16, 2007.

10 45 C.F.R. §160.308.

11 45 C.F.R. §160.312(a).

12 45 C.F.R. §160.402(a); 42 U.S.C. §§1302d-5, 1302d-6.

13 4/24/07 Telephone Interview, *supra* note 3.

14 *See* HHS, *Compliance and Enforcement*, *available at* http://www.dhhs.gov/ocr/privacy/enforcement/numbersglance.html (last visited April 30, 2007); Marilou King, OCR, Presentation at the Fourteenth National HIPAA Summit: HIPAA Privacy Rule Enforcement at 3 (March 29, 2007) (*hereinafter* HIPAA Summit Presentation).

15 *Id.*

16 OCR uses the terms complaints or cases interchangeably, although sometimes multiple related complaints may be combined into one investigation. 4/24/07 Telephone Interview, *supra* note 3.

17 As explained on HHS' website, OCR must know the identity of the person who filed the complaint and have a way to contact that person; otherwise the case will be closed. *See* HHS, *Compliance and Enforcement: What OCR*

Considers During Intake & Review of a Complaint, *available at* http://www.dhhs.gov/ocr/privacy/enforcement/complaintreview.html.

[18] *Id. See also* HIPAA Summit Presentation, *supra* note 14 at 3.

[19] *See* HIPAA Summit Presentation, *supra* note 14 at 4-7.

[20] *Id.* at 8.

[21] *Id.* at 3; HHS, *supra* note 14.

[22] HHS, *supra* note 14.

[23] HHS, *supra* note 2.

[24] HIPAA Summit Presentation, *supra* note 14 at 16; HHS, *Privacy Rule Enforcement Highlights*, *available at* http://www.dhhs.gov/ocr/privacy/enforcement/highlights.html (last visited April 30, 2007).

[25] HIPAA Summit Presentation, *supra* note 14 at 15; HHS, *supra* note 24.

[26] *See* HHS, *Compliance and Enforcement: All Case Examples*, *available at* http://www.dhhs.gov/ocr/privacy/enforcement/allcases.html (last visited April 30, 2007).

[27] *Id.*

[28] *Id.*

[29] 4/24/07 Telephone Interview, *supra* note 3.

[30] *See* HHS, *supra* note 24. OCR may also refer some cases to CMS if the complaint contains information about an incident that could also be a violation of the HIPAA Security Rule.

[31] *See* Plea Agreement, *United States v. Gibson*, No. CR04-0374RSM, 2004 WL 223785 (W.D.Wash. Aug. 19, 2004) (alleging that an employee of the Seattle Cancer Care Alliance used a patient's name, date of birth an social security number to obtain a credit card in the patient's name); *United States v. Ramirez*, No. 7:05CR00708 (S.D.Tex. Aug. 30, 2005) (alleging that an employee in a Texas medical practice sold a patient's medical records); *United States v. Ferrer*, No. 06-60261 CR-COHN (S.D.Fla. Sept. 7, 2006) (alleging that an employee in a Florida medical clinic sold individually identifiable health information on more than 1,100 Medicare patients to her cousin, who used the information to submit approximately $2.8 million in fraudulent Medicare claims).

[32] *See, e.g.*, Doreen Z. McQuarrie, *HIPAA Criminal Prosecutions: Few and Far Between*, U. Houston Health Law Perspectives, Feb. 19. 2007, *available at* http://www.law.uh.edu/healthlaw/perspectives/2007/(DM)HIPAACrimCharges.pdf.

[33] 4/24/07 Telephone Interview, *supra* note 3.

Health Information Technology

Move to EHR requires stakeholder buy-in, experts stress

by Catherine Hubbard, M.A., Contributing Editor

When implementing electronic health records (EHRs) and information exchange, providers need to coordinate their efforts, ensure stakeholder buy-in, and assure the public that the move will not threaten their privacy, speakers explained during a recent Healthcare Financial Management Association audio conference on regional health information organizations (RHIOs).

The role of RHIOs. RHIOs are an effort at the state and local level to facilitate exchange of EHRs and health information through groups of organizations interested in improving the quality, safety, and efficiency of health care delivery. The RHIO computer networks receive, collate, and distribute information among members of the network.

Jill Gordon, an attorney with Davis Wright Tremaine, Los Angeles, California, noted that RHIOs police and impose policies on end users. She advised keeping in mind that there are two layers of responsibility — one at the entity level and one at the user level. She also emphasized the importance of making sure there is buy-in at the individual user level so the network actually gets used.

Stakeholder buy-in. Gordon also stressed the need for getting participants in the RHIO on board in terms of how they view the information exchange, and getting adequate representation from participant entities that are vested in the project.

Donald Holmquest, CalRHIO president, said it is easy to understate how many stakeholders there are in the process, including privacy advocates, consumers, payers, hospitals, medical associations, and physicians. "I think you've got to get all those key players in place," he added, emphasizing that in a process this new, it is important not to leave anyone out. "Consensus is huge and if you mess that up you will pay terribly for it."

The need for EHR. Between 48,000 and 60,000 people in California each day are harmed because health information is missing. "On average, every business day in California, more than 50,000 patients are receiving suboptimal clinical care solely because we do not have a comprehensive method for moving patient records where and when they are needed," Holmquest noted.

Holmquest stated that without access to electronic health information, 30 percent of the time physicians cannot find information previously recorded in a paper chart; half the time patients agree to duplicate testing; and one in seven admissions to a hospital and one of five lab tests and radiology exams are the result of an inability to retrieve information. On average, test results come from five or more locations, delivered via mail, fax, e-mail, messenger, and telephone.

Despite these statistics, the public tends to worry more about identity theft or violation of privacy in an era of electronic health information exchange. "We have more people harmed every day by missing information than we have people having identity theft problems in a year," according to Holmquest.

The need for public education. Anne Cramer, with Primmer Piper Eggleston & Cramer, stressed the need for public education. "You really need to have an education effort so that the public has confidence in this system and confidence in the privacy and security measures in that they are willing to adopt it," Cramer said.

As an example, Cramer cited a Vermont organization that holds discussions with consumers, physicians, and advocacy groups, listening to their concerns and giving them a chance to learn how the organization is addressing them. "This isn't big brother," she added. ■

CCH Washington Bureau, May 29, 2007.

Tax-Exempt (cont.)

compensation on Form 990. Their advice was provided against the backdrop of the Compensation Project, as well as the Government Accountability Office's (GAO's) Survey on Executive Compensation Policies and Practices (*See* GAO Report, June 30, 2006, *Health Care Compliance Reporter*, ¶530,072). Fish and Hyatt advised:

- **Be "990 literate."** The board or compensation committee must be "990 literate," which requires that those responsible for making executive compensation decisions know and understand what is on the Form 990. According to Hyatt, this is an increasingly important obligation in light of the new Form 990 and the increase in the amount of excise tax imposed for engaging in an "excess benefit transaction" under the Pension Protection Act of 2006.
- **Use nonprofit comparables.** In making decisions as to what is "reasonable" compensation for a nonprofit executive, it is acceptable to utilize for-profit comparables. Fish advised, however, that using nonprofit comparables in determining an appropriate level of executive compensation will be viewed more favorably by the IRS and is less likely to result in an examination.
- **Follow conflict of interest policies.** It is critical to have a conflict of interest policy, and it is imperative that the policy is followed. "Adopting a policy only gets you part way," Hyatt said.
- **Establish "accountable plan" policies.** Hyatt cautioned that nonprofits should explicitly define what constitutes an "accountable plan." Failure to do so may result in an automatic excess benefit problem. Benefits not provided for in the accountable plan are treated as compensation and, therefore, become an excess benefit transaction.

According to Hyatt, while the new Form 990 will bring more transparency into the executive compensation practices of nonprofits "than ever before," hopefully placating concerns about unreasonable compensation, these compliance practices can help tax-exempt organizations avoid an IRS examination, including the type initiated by the Compensation Project. ■

CCH Washington Bureau, May 25, 2007.

In the News

Drug maker fined for false statements

Bristol-Myers Squibb (BMS) has agreed to pay a $1 million criminal fine for lying to the federal government about a patent deal involving a popular blood-thinning drug, according to the Department of Justice (DOJ). The DOJ said that the company's illegal actions threatened to reduce competition for the drug Plavix that could have reduced the cost of blood-thinning drugs. According to the indictment, BMS and Apotex, Inc., were negotiating a settlement of litigation over the validity of the patent for Plavix, pursuant to which BMS agreed not to launch its own generic version of Plavix that would compete against Apotex for generic sales. After being warned by the Federal Trade Commission (FTC) that such a settlement would not be approved, BMS concealed the agreement and lied about its existence to the FTC. The DOJ charged BMS with filing two false statements as part of its effort to hide its settlement with Apotex.

DOJ Press Release, May 30, 2007.

Hospital, DOJ settle antitrust allegations

The Department of Justice (DOJ) and the state of Arizona have settled with the Arizona Hospital and Healthcare Association and its subsidiary, prohibiting the organizations from (1) agreeing on competitively sensitive contract terms, and (2) discriminating against agencies or hospitals that opt not to participate in the Association's group purchasing organization. According to the DOJ, the organizations' actions caused the bill rates paid to agencies, and ultimately the wages paid to temporary nurses in Arizona, to stagnate and fall below competitive levels. Thomas O. Barnett, Assistant Attorney General for the DOJ's Antitrust Division said, "Today's action restores competition in the market for temporary nursing services, which not only will benefit nurses, but also [will] help to improve patient care in Arizona."

DOJ Press Release, May 22, 2007.

CMS emphasizes community-based services

Thirteen states and the District of Columbia will get more than $547 million in grants over five years to build Medicaid long-term care programs that will help keep patients at home and out of institutions, according to CMS Acting Administrator Leslie V. Norwalk. These awards are the second round of grants that will total $1.75 billion over five years to help shift Medicaid's traditional emphasis on institutional care to a system offering greater choices that include home and community-based services. This initiative was included in the Deficit Reduction Act of 2005 and is part of a nationwide effort to (1) remove barriers to community living for people with disabilities or chronic illnesses; (2) increase state Medicaid programs' ability to assure continuity of care for individuals who choose to move from an institutional to a community setting; and (3) ensure quality improvement for home and community-based long-term care services for Medicaid beneficiaries.

CMS Press Release, May 14, 2007.