

Health Care Compliance LETTER

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IRS sends questionnaire to learn more about tax-exempt hospitals

by Alison Reynolds, Contributing Editor

The Internal Revenue Service (IRS) sent out Form 13790, Compliance Check Questionnaire Tax-Exempt Hospitals, in May, 2006, as a follow up to its announcement last fall that it planned to learn more about the tax-exempt hospital industry, according to an IRS spokesperson. Nothing should be read into the delay between its announcement and the May mailings, the IRS noted.

Along with Form 13790, the IRS sent out a letter greeting the taxpayer and also a standard Form 4386, Compliance Checks, Examinations, Audits, Questions & Answers, which explains that there is no penalty associated with failing to return the compliance check but that the IRS has the option of opening a formal examination whether or not the organization agrees to participate.

The questionnaire is split into three parts. Part 1 asks for basic identifying information. Part 2 addresses community benefit activities and governance and includes 72 questions on specific areas of community benefit that address the key points of the Revenue Ruling 69-545 community benefit standard. Part 3 asks about compensation practices.

Purpose of questionnaire. Form 13790 was selected to determine what tax-exempt hospitals were doing to justify their claimed tax-exempt status. The IRS decided that the Form would handle a good portion of the data it needed to collect and interpret results, the IRS spokesperson said.

The IRS is specifically looking for characteristics that would distinguish a tax-exempt hospital from a for-profit hospital. It wants especially to assess the differences from the perspective of the benefits the tax-exempt hospital is providing to the community.

Selection of hospitals. Only tax-exempt hospitals have received Form 13790. To compile the list of hospitals to which the form was sent, the IRS reportedly took a list of health care institutions and determined by Google if they were a tax-exempt hospital. It then eliminated clinics, public hospitals, parent holding companies, and bankrupt hospitals from the list so that only operating 501(c)(3) hospitals remained, according to the IRS spokesperson.

All questionnaires have been mailed out, however, at press time, no responses had been received.

Follow-up. The IRS plans to collect the data and then try to analyze the overall situation in the tax-exempt hospital community. While specific audits are not the intention of the IRS in sending out the questionnaires, the IRS will likely investigate further if something especially suspicious or startling pops up on the form, the IRS spokesperson said.

The IRS has been unclear on how the general standards enunciated in Rev. Ruling 69-545 relate to a tax-exempt hospital's practice, especially as applied to the present health care system.

Response to Senate Finance Committee. The IRS spokesperson said that it would be up to Senator Grassley's discretion whether to release the responses the IRS provides to the Senate Finance Committee regarding tax-exempt hospitals. There is no timeline in place as of now, however, for formulating responses to Senator Grassley's request. ■

CCH Washington Bureau, June 5, 2006.

Experts focus on ways to determine self-pay ability, increase charity care

by Catherine Hubbard, M.A.,
Contributing Editor

Helping patients to determine their ability to pay can help hospitals lower their bad debts, reduce fraud, and increase charity care, according to experts who spoke during a May 25, 2006, webcast sponsored by the Health Financial Management Association (HFMA).

Identifying ability to pay. When billing patients, it's difficult to distinguish those with ability to pay versus those who qualify for financial assistance, said Thomas Mathews, business development manager for TransUnion's healthcare division. "The uninsured and underinsured populations aren't necessarily people who don't have the ability to pay," he said. The fastest growing uninsured group is those making \$50,000 or more per year, he added.

Meanwhile, the typical charity and Medicaid enrollment processes are manual, cumbersome, and can be error prone, Mathews said, noting there are technologies to automate the process. These tools can be used in financial triage to isolate patients who have missing data, mismatched data or who could be helped by various assistance programs. "Where there are tools available, it's important that you use them," he said.

Using technology driven data, hospitals can mitigate financial risk. "You have the ability to collect information on patients' status in real time," he said, adding that failure to properly identify patient information up-front can result in delinquencies and write-offs. "We need to find out who that person is sitting in front of us and make good decisions," he said.

During financial triage, health care workers should verify the patient's address and other personal information, Social Security number, and whether the patient qualifies for financial aide. "It's a great place to start that dialogue," Mathews said.

Kimberly Back, patient access manager at Valley Medical Center, said her company uses TransUnion's Healthcare revenue cycle software as a dialogue tool to get more information from patients, validate the information, obtain information on poverty levels, and obtain credit scores. It enables employees to quickly enter and process information such as whether the patients are U.S. citizens, are pregnant, qualify for Medicaid, have a potential disability, are legally blind, have private insurance, are a victim of crime, or have children and other factors that can indicate whether they qualify for assistance.

"We have lowered bad debt and increased charity," Back said. "It's been a good [public relations] PR tool." She noted the organization has not received pushback from patients due to the added questions or the few extra minutes it takes to assess their financial situations.

Credit reports. Under the Fair Credit Reporting Act, when a patient solicits services, the provider has permissible purpose to do a query of his or her credit information, said Mathews, adding that the employee can use that information to assess the patient's self pay ability. He warned, however, against relying solely on the credit score to determine how much the patient should pay, noting that an elderly person may have a good credit score, but no income.

While a credit check can help determine ability to pay, some people who have never applied for credit may not have a credit history, Mathews said. "There are other databases to confirm who they are," he assured participants. One tool is reverse phone look-up. Databases provided by the mail services are good, too, but they don't confirm the person actually lives at the address provided. "Accessing other databases to verify that information is critical," he said.

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Requests for information about article submission and comments from readers are welcome and should be directed to Susan Smith at susan.smith@wolterskluwer.com, Tel. 847-267-2780, Fax 847-267-2514. Customer service inquiries should be directed to 800-449-9525.

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Approaching patients. Although hospitals have the right to assess self pay ability and require payment, they should be considerate of patients when asking for money, Mathews said. "You can present options to them in a friendly way," he said. One way is to ask how the person wants to pay or with which credit card, he suggested.

After triage, the hospital can continue to use technology to prioritize the collectability of the debt based on patients' finances. "Get a recovery score," Mathews recommended. In addition, it's important to track all the benefit programs, which will help increase charity care and send a positive message to the community.

CCH Washington Bureau, May 25, 2006.

ACT recommends revisions to Form 990/ tax exempt bond audits

by Allison Reynolds,
Contributing Editor

Guidelines for the revision of Form 990 were among recommendations presented by the Advisory Committee on Tax Exempt and Government Entities (ACT). Form 990 has grown to be a complex document that is difficult for many tax-exempt organizations to navigate and has shifted from its primary goal of information reporting to the Internal Revenue Service (IRS), according to the ACT committee. The ACT presented its 5th Annual Report of Recommendations to Steven Miller, Commissioner, Tax Exempt and Government Entities (TE/GE), IRS, and other key IRS officials on June 7 in Washington DC.

The ACT also found that IRS tax-exempt bond audits were having a distorted effect on the bond community, including misinformation as well as unnecessary repetitive mistakes being made because audit results were not being shared. The ACT believes that disclosure of adverse determinations

to the bond market would help fix this problem.

Form 990 revisions. According to an IRS official, plans have been underway to revamp Form 990 and the suggestions made by the committee would be considered in its final design. The ACT recommended that:

- Form 990's primary purpose should be to assess whether the filer complies with federal tax requirements;
- Form 990 should accommodate informational needs of states so long as it does not interfere with IRS's primary mission;
- Form 990 and instructions should be understandable to persons unschooled in the law of tax exempt organizations;
- Form 990 should consist of a core form with schedules organized by topic and type of organization;
- Questions on Form 990 should be formulated to obtain evidence or facts that will reveal readily whether the filer has complied with federal tax law;
- Current statutory quotas on mandatory e-filing should be removed and e-filing should be phased in; and
- Form 990 should be redesigned in its entirety and implemented as quickly as possible.

Effects of IRS audits on tax exempt bond market. In recent years, the IRS has stepped up its audits on tax-exempt bonds. The ACT recognizes that the IRS considers such determinations to be private and will not disclose this information because of Code Sec. 6103. The ACT committee wants to find a way to encourage disclosures by issuers and borrowers to help improve the tax-exempt bond audit process.

The ACT recommended that the IRS Tax-Exempt Bond division to create an internal policy regarding media contacts and create a media relations liaison that would help broadcast information to the financial markets. The ACT also maintains that the IRS should find a way to share the information learned from the audit program as to compliance errors. This is referred to as "soft guidance."

IRS officials noted that currently there are links on the IRS website under the tax-exempt bond community heading that share compliance information with the public. In particular, they pointed to compliance information on abusive tax-exempt bond arrangements that tax-exempt bond issuers might find particularly useful. ■

CCH Washington Bureau, June 7, 2006.

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Joint venture imaging centers, Part I: Identifying compliance issues

by Paul R. DeMuro, C.P.A, M.B.A, J.D., and Katherine A. Lauer, J.D.,
Contributing Editors

Joint venture imaging centers have proliferated vastly in recent years, as radiologists, referring physicians and management company investors have taken advantage of the opportunity for substantial returns in exchange for relatively minimal outlays. But these ownership structures are not free from compliance risk and various payors have begun to question whether the profit motives created by imaging joint ventures lead to overutilization or influence the judgment of physician owners regarding patient referrals. This article discusses the ways in which imaging joint ventures can be structured to minimize the risk of regulatory enforcement, while still allowing financial benefits to be earned commensurate with investment risk.

There are estimated to be more than 5,000 free-standing imaging centers around the country, many of which are structured as joint ventures. Physicians, hospital radiology practices, or hospital outpatient departments also can provide diagnostic imaging services, and these practices and departments sometimes have joint venture elements to them. The diagnostic imaging modalities provided vary considerably from venture to venture as does the make-up of the physician investors. Typical diagnostic imaging modalities provided in a joint venture setting include the following: x-ray (traditional and digital), mammography, angiography, cardiac catheterization, ultra sound, computed tomography (CT), magnetic resonance imaging (MRI), and nuclear medicine.

In 1998, CMS created a new category of provider for Independent Diagnostic Testing Facilities (IDTF). Diagnostic facilities that are not physician practices owned by physicians or hospitals and do not provide therapeutic or physician services to patients not treated in the practice are required to enroll in the Medicare program as an IDTF to treat and bill Medicare patients.

Interest in imaging joint ventures historically has been high among radiologists, nonradiologists seeking to perform imaging procedures, referring physicians, equipment manufacturers, wholesalers, salespersons, lenders, financing companies, third-party management companies, consultants, including valuation consultants and attorneys. Hospitals including hospital chief executive officers and chief financial officers, the American Hospital Association, and health plans, appear to be less interested in developing imaging joint ventures, particularly when referring physicians may be part of the joint venture. Hospitals view such ventures as cannibalizing or siphoning off their existing business.

In Part I of this article, the potential compliance issues associated with structuring joint venture imaging centers are identified and discussed. Part 2 will explore strategies for avoiding liability.

Regulatory Framework

A study conducted among physicians in Florida, prior to the implementation of the Stark self-referral statutes, suggested that physicians who own an interest in imaging equipment or imaging centers referred patients for imaging services more often than did those physicians having no such ownership interests. A Blue Cross and Blue Shield Association study “suggested” that joint venture parties were fragmenting their imaging services, e.g., putting different modalities in different joint ventures and entering into a number of “creative” arrangements. These studies documented how investment arrangements can affect referrals and increase health care costs. The potential impact on costs, particularly in the federal healthcare programs, is one reason why the Office of Inspector General (OIG) is interested in limiting such investments among physicians or other referral sources.

One of the most challenging regulatory issues involves structuring an imaging joint venture to comply with the Stark laws, which prohibit referrals of designated health services (DHS) absent an exception. DHS includes radiology and certain imaging services included within the applicable current procedure terminology (CPT®) and health care procedure code system (HCPCS) codes. Included DHS are MRI, CT, and ultrasound. Nuclear medicine becomes a DHS in 2007.

The anti-kickback statute is another concern for joint ventures that include physician investors. It prohibits paying a physician, or any other person, remuneration with the intent to induce the referral of beneficiaries of the federal health care programs.

The Attraction of Joint Ventures

The joint venture structure attracts players from all sides of the healthcare industry. Referring physicians often believe they are either underpaid or can make more money by “owning a piece

of the action” or part of the “technical component.” Part of the underlying policy rationale for the Stark self-referral prohibitions and the anti-kickback laws is that referring physicians believe that there would not be any “action” (procedures) if it was not for them. Radiologists contend that when patients are referred to them and the procedures are done in a hospital outpatient department, the only reimbursement they receive is for the professional component of the procedure, which does not truly recognize their value. Nonradiologists who can perform certain imaging procedures for these patients, such as cardiologists performing cardiac catheterizations, also want a piece of the action.

One explanation for the proliferation of joint ventures is the potential for a good payor mix and the availability of entities to fund such ventures. Typically, joint ventures do not see a large number of Medicaid and no-pay patients because those patients are often not referred by physicians to the joint venture. For this reason, equipment manufacturers, wholesalers, salespeople, lenders and financing companies historically have been willing to extend very favorable terms to joint ventures, particularly when they include many physician investors. Numerous management companies, consultants and attorneys stand ready to “assist” and many management companies are willing investors. Even hospitals are motivated to invest, driven by the fear they will lose a large portion of their outpatient imaging business if they do not.

A key component in the growth of imaging joint ventures has been low interest rates and the availability of entities to fund such ventures. The low interest rate climate, however, is changing, which has caused some joint ventures to be structured in such a way that the physician venturers contribute no money or other property to the venture. This structure implicates numerous legal and regulatory schemes, including the Medicare and Medicaid anti-kickback statutes, the Stark self-referral prohibitions, the antitrust laws, and, for tax-exempt hospitals, the tax-exemption principles.

Financial Arrangements in Joint Ventures

Consider the following “no money in” example for a CT scanner:

Equipment Manufacturer/Lender:	Lends the cost of the equipment and all related items, plus working capital that is used to pay for supplies, technicians, etc.
Landlord:	Provides three months free rent and/or puts the cost of the first three months rent and tenant improvements in the remainder of the lease.
Physician Medical Directors:	Defer administrative compensation, if any, for three months.
Equipment Manufacturer Lender and/or Management Company:	Handles most of the start-up details, Medicare certification, managed care contracting, etc., and could be part of its deferred fee.
Promoters:	Pay for the cost of putting the joint venture together, e.g., Offering Memorandum [Query: Does the joint venture reimburse them?]
Investors, including Physicians:	Contribute Guarantees.

Guarantees

One method that has been used to limit or even eliminate cash outlays by physicians and other members of joint ventures is to allow the physicians to guarantee a portion of the joint venture’s debt in exchange for an ownership interest. These guarantees may be limited to the pro rata share of the physician’s ownership interest or may be joint and several among all investors. Guarantees can be very appealing to physicians who do not want to put money into a joint venture, but, as discussed below, they do present a heightened level of regulatory risk.

Prospective joint venture parties may consider developers or promoters who have a track record when the guarantees of the physician investors have never resulted in the physicians having to put any money into the venture. Those parties may be able to attract physicians to new joint ventures more easily, although questions could be raised as to whether the physicians are actually “at risk” in the venture if there is no real chance that the physician could be called upon to perform under the guarantee.

An additional question arises if all a physician puts into a joint venture is a guarantee and he or she receives \$50,000 at the end of a year for his or her interest in the venture. What is his or her return on investment (ROI)? It appears to be infinite. To reduce these regulatory risks, as well as to reduce the amount of working capital that the joint venture needs to borrow, some joint ventures do require at least minimal contributions from the physicians in cash or property.

Additional Value for Referring Physicians

In addition to ownership interests, some imaging joint ventures have other financial arrangements with their physician referral sources. In some joint ventures, nonradiologists may be afforded certain directorships or administrative positions for which they receive compensation. Questions may be raised regarding whether these payments represent legitimate payments for necessary services, or

whether the physicians are being incentivized to refer. When not prohibited by state laws or regulations, some imaging joint ventures lease the imaging technology on a “per click” basis to referring physicians, affording the physicians the ability to bill for both the technical and the professional component of the service. The referring physician may need to contract with a radiologist to “read” or “over read” the study, and the radiologist will have to be compensated by the referring physician. Under this model, when the technical component is leased to the physicians at a lower fee than the physician is able to bill payors for the technical component, the referring physician profits from the “spread.”

Serial Same-Site Joint Ventures

Additional regulatory risk is presented when different modalities are “split” into separate joint ventures. Consider three joint ventures at one site, for example. In addition to the CT venture noted above, assume that two additional ventures, one for MRI services and one for traditional and digital radiography, are formed and exist side-by-side in the same building, sharing overhead, personnel, and other costs.

CT Scanner	Radiology	MRI
Suite A	Suite B	Suite C

Assume that each joint venture is separately organized as a limited liability company (LLC) or limited partnership (LP) and qualifies as an IDTF and each venture has a separate address, e.g.: 101 Main Street, Suites A, B and C. Finally assume that the physician owners of each venture cannot refer government program patients to the venture in which they have an interest because of Stark’s prohibitions. What if the physicians in each joint venture instead refer all of their government program patients to the other two joint ventures in which they do not own an interest? Certainly, there is a risk that the government could contend that the structure is a circumvention scheme subject to Stark’s penalties.

Health Plan Concerns

Serial same-site joint ventures appear to be the target of the ire of a number of health plans. Health plans are concerned that the fractionalization of joint ventures that exist at serial same-site locations could lead toward over utilization.

In addition, these arrangements lead to increased managed care costs for commercial health plans. Hospitals in markets where such joint ventures exist complain that these joint ventures leave the hospitals with the less lucrative patients. Therefore, the hospitals argue they need higher managed care rates for such outpatient imaging services or higher managed care rates across the board to compensate the hospitals for these “losses.”

Responses

Health plans. Health plans have questioned the payor mix of some facilities, and some have sought to require more than one imaging modality at a particular site. Health plans have sought to require the availability of services over a greater period of time, e.g., the IDTF must be open for X hours per week or open on Saturday and have refused to pay for “per click” lease or “purchased service” arrangements. Some have even inserted themselves into decisions regarding the appointment of medical directors and the supervision of services at these joint ventures. Health plans have taken these actions even though the joint venture IDTFs will accept less reimbursement than imaging service providers at a hospital outpatient department.

Hospitals. As noted above, hospitals have communicated with health plans about why hospital outpatient rates for these services must be greater, but what about hospitals participating in such joint ventures? Their returns may be better than just having a hospital outpatient service because those hospitals also have “managed” part of their potential competition. On the other hand, hospitals have to be concerned about upsetting their medical staffs. A physician who might make \$50,000 a year by participating in such a venture will not be happy if his or her flow of funds is eliminated by a hospital or health plan’s actions.

Part 2 of this article, which will be published in the next *Health Care Compliance Letter*, will address structural considerations for joint ventures including directorship agreements, lease agreements, and management fees.

Paul R. DeMuro is a partner in the Los Angeles and San Francisco offices of Latham & Watkins LLP. He is a CPA with an MBA in finance who has practiced corporate and health care law since 1979. Mr. DeMuro has practiced extensively in the areas of corporate transactions, joint ventures, mergers and acquisitions, corporate organization, governance, finance and regulatory compliance. He works with hospitals, health plans, e-health and health care technology companies, medical groups, physician practice management companies and integrated delivery systems. He also practices in the areas of Medicare reimbursement, fraud and abuse, compliance and managed care. He is a member of the Health Care Compliance Editorial Advisory Board.

Katherine A. Lauer, J.D., is a partner in the San Diego office of Latham & Watkins. Recognized by Nightingale’s Healthcare News as an “Outstanding Fraud and Compliance Attorney” (2004), Ms. Lauer’s practice focuses on defending major civil and criminal healthcare fraud investigations and False Claims Act cases. Her clients include HCA, Tenet and Catholic Healthcare West. She has particular expertise in relationships between hospitals and physicians, and speaks and writes frequently at national conferences on various topics, including the federal Anti-kickback Statute, the Stark Laws and the Federal False Claims Act. Ms. Lauer is a 1988 graduate of the University of Michigan School of Law, where she also received a B.A. in political science.

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Voluntary compliance guidance for federal research funding recipients to be expanded

Susan L. Smith, J.D., M.A.,
Contributing Editor

The Office of Inspector General (OIG) has concurred an offer from the Committee on Science (COS), National Science and Technology Council (NSTC) to expand upon OIG's initial efforts to provide voluntary compliance guidance to recipients of federal research funding, according to Inspector General Daniel R. Levinson.

Voluntary compliance guidelines. The COS concurred that their Research Business Models Subcommittee will establish an interagency initiative to develop voluntary compliance guidelines for recipients of federal research funding from all agencies across the federal government. "The COS offer will further the goals of our draft compliance program guidance by providing voluntary guidance to all recipients of federal research funding as they address the prudent management and stewardship of research funds," Levinson said.

"This project is ideally suited to the Research Business Models Subcommittee, which promotes common policies and procedures among federal research agencies. The idea is not only to enhance their efficiency but also to reduce bureaucratic impacts on their constituents. This topic has become more important as compliance requirements have increased substantially in recent years," said Dr. John H. Marburger III, Director of the White House Office of Science & Technology Policy (OSTP).

OIG's draft guidance. OIG's "Draft Compliance Program Guidance for Recipients of PHS [Public Health Service] Research Awards" (Draft Guidance) was developed to provide recipients of research awards from HHS agencies with a framework for developing and implementing effective compliance programs that prevent and reduce fraud, waste, and abuse, as well as promote adherence to federal rules and regulations. The Draft Guidance was published for

public comment in the *Federal Register* on November 28, 2005 (see *Health Care Compliance Reporter*, ¶510,022).

Streamlining the process for managing federal research grants through consistent government policies and procedures is a priority of the COS and OSTP. For example, in January 2005, OSTP and the Office of Management and Budget, working with the research community and government agencies through the Federal Demonstration Partnership, proposed the establishment of a core set of terms and conditions on research awards to allow for a more flexible and efficient use of federal research funds by institutions and standardize the management of research grants by federal agencies. ■
OIG Press Release, June 7, 2006.

Semiannual report outlines Part D implementation, Medicaid oversight

by Sheila Lynch-Afryl, J.D.,
Contributing Editor

The Office of Inspector General (OIG) expects recoveries of \$1.02 billion from efforts to reduce fraud, waste, and abuse in HHS programs during the first half of fiscal year 2006, according to its semiannual report. In addition, 1,540 individuals and organizations were excluded for fraud or abuse, 226 criminal actions were initiated, and 119 civil actions, including False Claims Act and unjust enrichment suits, were filed in district courts. The OIG's oversight focused on Medicaid integrity, Medicare Part D implementation, and the response to Hurricanes Katrina and Rita.

Medicaid program integrity. The OIG's accomplishments for the period included oversight focused on Medicaid integrity. For example, the OIG audited four states' calculations of upper payment limits for payments to hospitals and nursing facilities and found potential federal overpayments of \$243.2 million, which resulted from the states' failure to follow federal regulations and state plans.

Enforcement actions. Enforcement actions for the period included a global crimi-

nal, civil, and administrative settlement with Serono, S.A., and its U.S. subsidiaries, which agreed to pay \$704 million plus interest to resolve allegations that it illegally promoted its AIDS drug Serostim and made prohibited payments to doctors and pharmacies to induce them to prescribe and purchase Serostim. In addition, SmithKline Beecham Corporation agreed to pay the government \$149 million to settle allegations that it engaged in improper pricing and marketing practices for two antiemetic drugs.

For the first time, the OIG excluded a hospital from participation in the federal health care programs based on the hospital's material breach of a corporate integrity agreement previously negotiated as part of the resolution of a False Claims Act case.

Implementation of Part D. The report highlighted an early implementation review that examined whether Part D prescription drug plans' (PDPs) formularies included drugs most commonly used by dual eligibles. Although most of the drugs reviewed were included on PDP formularies, the study that found that, due to the variation among PDP formularies and the medical and resource challenges faced by this population, dual eligibles may need targeted assistance to navigate the transition from Medicaid to the new Medicare Part D benefit.

Hurricane-related activities. The OIG has initiated extensive audit, inspection, and investigative activities related to the oversight of HHS hurricane recovery effort, according to the report. For example, an OIG audit will determine whether HHS is appropriately accounting for hurricane-related costs. In addition, it is evaluating the performance of a contractor in charge of returning evacuees who cannot travel via commercial air without medical assistance.

In addition, pursuant to a request by the Senate Special Committee on Aging, the OIG will conduct a study of nursing home facility evacuation planning and execution. The study will determine whether these homes complied with federal requirements to develop and practice emergency preparedness plans and whether the plans included the evacuation of residents. ■

OIG Semiannual Report, June 2, 2006, Health Care Compliance Reporter, ¶540,045.

CMS acts to protect beneficiaries from breach of security

by **Dionne Muhammad, J.D.**,
Contributing Editor

Based on two unrelated security breaches involving personally identifiable information, CMS has taken action to assure that the affected beneficiaries are protected from similar events in the future. CMS learned from the Office of Inspector General that a computer file containing personally identifiable information for approximately 17,000 Medicare beneficiaries was not maintained securely. In another incident, approximately 250 member applications were stolen from an insurance agent's vehicle in Minnesota in April 2006.

Carrier corrective action plan. CMS has required the carrier involved in both instances to implement the following set of corrective actions: (1) contact all affected beneficiaries, (2) provide beneficiaries free access to a credit monitoring service for one year, and (3) submit a comprehensive corrective action plan.

CMS will closely monitor the carrier's activities to ensure that this corrective action plan is fully implemented, CMS Administrator, Mark McClellan stated. These matters also are being reviewed to determine what additional compliance and enforcement actions, including those under the Health Insurance Portability and Accountability Act (PubLNo 104-191) security and privacy rules, may be warranted.

McClellan stated that CMS has established and enforced a broad range of privacy and information security protections and is working with federal and state partners to monitor and enforce these requirements. Cautioning employees, contractors and health plans about the penalties for violating the privacy, security, and information laws and regulations, McClellan added that CMS will take aggressive actions against any plan or Medicare contractor that compromises the privacy and security of beneficiaries' personal information. ■

CMS Release, June 5, 2006.

In the News

House approves FY2007 appropriations bill

The House Appropriations Committee approved the fiscal year 2007 Defense and Labor-HHS-Education appropriations bills, which includes \$454.6 billion mandatory spending. The bill provides \$540 million for immunization programs for needy children, \$2 billion in funding for community health centers, \$313 million to critical programs that improve the availability of well-trained health care professionals to underserved areas, and \$113 million for community-based abstinence education programs. In addition, the bill rejects many of the Administration's budget cuts to critical rural health programs and earmarks funds that will expand health care opportunities for rural communities including rural hospital flexibility grants and telehealth activities.
Committee on Appropriations, June 13, 2006.

Campaign to reduce medication mistakes launched

The U.S. Food and Drug Administration (FDA) and the Institute for Safe Medication Practices (ISMP) are working together on a nationwide health professional education campaign aimed at reducing the number of common mistakes caused by the use of unclear medical abbreviations. According to the Institute of Medicine (IOM) of the National Academies, there are more than 7,000 deaths a year due to medication errors. The campaign will address the use of mistake-prone abbreviations in all forms of medical communication.

FDA Press Release, June 14, 2006.

Brownback, Ryan introduce health records act

Senator Sam Brownback (R-Kan) introduced the Independent Health Record Bank Act on June 6, 2006, which would establish a nationwide health information network for doctors and patients. Representative Paul Ryan (R-Wisc) introduced a companion bill in the House on June 8, 2006. The Act would provide legal and regulatory guidelines for the establishment of independent health record banks that would store a patient's electronic health records in effect creating a nationwide health information network. Under the approach outlined in the bill, based on the model used in the financial services industry, health records would be owned by patients, and the health record banks would be operated by nonprofit cooperative institutions, much like member-owned credit unions.

Sen. Brownback Press Release, June 6, 2006.

\$265 million settlement with NJ health system

The U.S. Department of Justice announced a \$265 million settlement agreement with New Jersey's St. Barnabas Corp. on allegations that the health system fraudulently increased prices to Medicare patients to obtain high cost outlier payments. The charges were initially brought in two separate law suits by three whistleblowers under the *Qui Tam* provisions of the False Claims Act. As part of the settlement, Saint Barnabas has agreed to enter into a corporate integrity agreement with the Office of Inspector General, which contains measures to ensure future compliance.

DoJ Press Release, June 15, 2006.