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Law & Business

Experts advise on documenting community benefit

by Vanessa Skawski, J.D., Contributing Editor

Tax-exempt hospitals are scrutinizing their methods of documenting community benefit in light of the Internal Revenue Service's (IRS) new compliance initiative directed at the manner in which tax-exempt hospitals satisfy the community benefit standard under Section 501(c)(3) of the Internal Revenue Code. Increasing concern as to whether tax-exempt hospitals provide community benefits sufficient to justify their tax-exempt status led to the creation of the new compliance program, in which selected hospitals have been asked to voluntarily complete a nine page IRS questionnaire.

Over 500 hospitals have been selected for a compliance check and asked to complete the IRS questionnaire, which includes over 80 questions on the hospital's satisfaction of the IRS community benefit standard for tax-exempt status. A recent American Lawyers Association teleconference addressed tax-exempt hospitals' concerns regarding the IRS new compliance program. Speakers discussed the IRS community benefit compliance project, the legal principles governing community benefit, and the planning and reporting of community benefit.

Compliance check. Topics covered on the questionnaire include emergency room operations, executive compensation, uncompensated care, community programs, and governing board practices. The primary purpose of the compliance check is to review whether an organization is adhering to recordkeeping and information reporting requirements and whether an organization's activities are consistent with their stated tax-exempt purpose. A hospital may refuse to submit to a compliance check without penalty. Participants from the IRS stressed that the purpose of the compliance check was to get a picture of what is going on in the tax-exempt hospital community overall and should not be interpreted as an audit. It is important to note, however, that while the IRS does not intend to, it could initiate and audit based on responses to the compliance check.

Defining community benefit. According to teleconference speakers Lisa J. Gilden, Esquire and Julie Trocchio of the Catholic Health Association, community benefits are programs that provide treatment and/or promote health and healing as a response to identified community needs. Community benefits, however, cannot be services provided for marketing purposes. At least one of the following criteria must be met for a service to meet the definition of community benefit:

- the service must produce little or no revenue;
- the service must address the needs of special populations;
- the hospital must be suppling services that would be discontinued if their existence was decided on a financial basis;

- the services must respond to public health needs;
- the services must involve education or research that improves community health.

Categories of community benefit. There are six main categories of community benefits, according to Gilden and Trocchio. One category is community health improvement services, which includes community health education, community-based clinical services, and health care support services. The category of health profession education includes hospitals' unreimbursed costs for medical, nursing, and other health professional education; however, the educational costs relating to hospital employees cannot be included in this category.

Another category of community benefit, subsidized health services, includes services that typically do not produce a great deal of income for the hospital, but would not be available to the community if the hospital discontinued them. Trocchio suggested that these are services that continue to lose money and the hospital cannot otherwise make business argument to keep. For example, a service that is a loss leader, or is provided at a loss but stimulates business in other areas, should not be considered community benefit. Subsidized health services could include neonatal intensive care, burn units, and emergency and trauma services.

The research category of community benefit includes both clinical research and community health research. The category of financial contributions can include cash donations, the legal services of the hospital's general counsel, or costs of fund-raising for community programs. Finally, the category of community building activities includes physical improvements and housing, economic development, community support, and community health improvement advocacy.

Trocchio also noted several items or activities that many hospitals are inclined to include as community benefit but shouldn't. Any program that is designed to help the organization in terms of public relations, marketing, or human resources, even if it is providing a service to the community, should not be included. For example, may health fairs, though beneficial to the community, are in reality a hospital marketing tool. In addition, bad debt should not be included. Bad debt is defined as a patient who refuses to pay a bill as opposed to a patient who cannot pay a bill. Trocchio suggested that hospitals identify as soon as possible those patients who are eligible for charity care to get them out of the bad debt category. Finally, in most cases Medicare shortfall cannot be included as charity care. As opposed to Medicaid, which can be included, Medicare is supposed to pay the full cost of care. On the other hand, if the hospital provides a service that is losing money and is primarily used by Medicare beneficiaries, there is a better case for including that service as charity care.

Telling a story. An important part of documenting community benefit, according to Gilden and Trocchio, is for hospitals to tell their community benefit story. Hospitals must identify their audience, develop their message, develop a media strategy, and incorporate their community benefit commitment into all of their communications. Additionally, hospitals should incorporate their community benefit story into their Form 990. Representatives from the IRS speaking at the teleconference instructed hospitals to describe their activities as broadly as possible, and explain what they include in research, education, and uncompensated care.

Finally, John R. Washlick, J.D., of the law firm Cozen O'Conner in Philadelphia, Pennsylvania, suggested that hospitals use the charity care check as an opportunity to assess their charity care situation. Even hospitals that were not mailed questionnaires should go through the exercise. He stated that many of the questions on the questionnaire could be audit questions down the road. ■

Documenting Community Benefit: How to Show the IRS You're Tax Exempt, AHLA Teleconference, July 11, 2006.

Correction

The two part *On the Front Lines* article entitled "Joint venture imaging centers, Part 1: Identifying comlpiance issues," and "Joint ventures imaging centers, Part 2: Preferred structural and restructuring considerations," written by Paul R. DeMuro, C.P.A., M.B.A., J.D., and Katherine A. Lauer, J.D. and published in Vol. 9 Issue 13, June 26, 2006, and Vol 9 Issue 14, July 10, 2006, respectively in the *Health Care Compliance Letter* should have included the language "©2006, Paul DeMuro, Katherine Lauer. All Rights Reserved. Reprinted with permission."

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Medicaid

Interim rule eases Medicaid proof-of-citizenship requirement

by Katherine G. Geraghty, J.D., Contributing Editor

In what was likely a response to recent pressure from patient advocates, CMS has issued an *Interim final rule* that will exempt seniors and people with disabilities who receive Medicaid from the new proof-of-citizenship rules announced last week. Patient advocates argued that the requirement could cause millions of needy people to lose their Medicaid coverage. While nearly eight million people will be exempt under the new rule, concern remains that an additional 40 million low income people may be at risk for losing coverage due to their inability to provide necessary documentation.

Exceptions. Under the interim rule, CMS will not require states to document the U.S. citizenship of individuals that are eligible for Medicaid automatically as Supplemental Security Income (SSI) recipients. Instead, CMS will rely on data matches with the Social Security Administration (SSA) to determine those recipients receiving SSI. The SSA's determination of SSI eligibility includes citizenship or alien status, as well as disability and financial eligibility.

The rule allows, but does not require, those states that do not automatically confer Medicaid eligibility on SSI recipients to determine citizenship by matching a name to an individual's Social Security Number using the State Data Exchange (SDX), which contains records of all determinations of U.S. citizenship made by the SSA. States also may use data from state vital statistics agencies to document citizenship for those individuals born in the U.S. If the vital statistics agency's records confirm that a birth certificate was issued, the individual need not produce a birth certificate. CMS has not determined whether states may verify citizenship through data matches with federal agencies other than SSA.

State agency requirements. For those who are not exempt from proof-of citizenship requirements, the new regulations require state agencies to give individuals a reasonable opportunity to obtain necessary documents. States must assist individuals in obtaining verification of citizenship, particularly individuals with disabilities. If the applicant or recipient has made a good faith effort to obtain documentation without success, the state may determine that the documentation is not available. In this case, the regulations do not specify whether the state will receive a federal funding match.

The regulations do not address concerns raised in two class action law suits challenging the documentation requirement, namely, the implications for individuals for whom no birth certificate ever existed, the homeless, disaster victims, and children placed in foster care or adoptive services. ■

Interim final rule, 71 FR 39214, July 12, 2006.

HIPAA

CMS creates HIPAA emergency planning tool

by Susan L. Smtih, J.D., M.A., Contributing Editor

A tool for advance planning purposes, which provides avenues of permissible disclosure of protected health information (PHI) that could apply during a public health emergency, has been released by the HHS Office of Civil Rights (OCR).

The tool focuses on the source of the information being disclosed, to whom the information is being disclosed, and the purpose of the information being disclosed. The user chooses the question that is most relevant to the emergency preparedness planning need and follows the information flow to find the appropriate answer. The definitions or special meanings are discussed on the relevant pages or will be linked to other locations on the OCR Web site. The tool is at www.hhs.gov/ocr/hipaa/decisiontool/.

Because the tool focuses on issues relevant to emergency preparedness, it does not present all the uses and disclosures permitted by the Health Insurance Portability and Accountability Act of 1996 Privacy Rule nor does it discuss all of the Rule's requirements. In addition, the tool does not address other federal, state or local confidentiality laws that may apply in specific circumstances. For example, disclosures permitted by the Privacy Rule for public health would generally be prohibited under the federal substance abuse confidentiality law. ■

CCH Chicago Bureau, June 29, 2006.

Part 1: What health care employers must know to comply with military leave laws

by William P. Schurgin, Esq., and Amanda A. Sonneborn, Esq., Contributing Editors

Since September 11, 2001, almost 530,000 members and reservists have been called to active duty. Of that number, approximately 150,000 of these individuals continue to serve in the military in Iraq, Afghanistan and elsewhere. Health care employers are often impacted by reserve and national guard call ups because of the need for medical specialists. This two part article will discuss the legal obligations of health care employers with respect to employees on military leave and the impact of a series of new federal military leave regulations that went into effect earlier this year.

In 1994, Congress enacted the Uniformed Services Employment and Reemployment Act of 1994 ("USERRA" or the "Act"). USERRA governs the rights of employees who temporarily leave their jobs as a result of their voluntary or involuntary service in the United States uniformed services.[1] More than 11 years after the enactment of USERRA, the Department of Labor (DOL) issued regulations to provide guidance to employers and employees in navigating their respective rights and responsibilities under the Act. The new regulations, which went into effect on January 18, 2006, explain the various provisions of USERRA and follow a user friendly question-and-answer format.[2]

"USERRA grants employees broad reemployment rights when they have been absent from their jobs because of 'service in the uniformed services.'"

USERRA provides protection to uniformed service members against discrimination and retaliation, establishes reemployment rights upon completion of military service, and addresses benefits such as access to health insurance while on leave. It applies to both public and private sector health care employers, and was designed to consolidate and simplify the rights of employees under the Veterans' Reemployment Rights Act, which previously determined the rights of individuals returning to their jobs following periods of uniformed service. USERRA covers all employers regardless of size.

Generally, USERRA prohibits employers from discriminating against employees in the areas of employment, reemployment, job retention, promotion, or any other benefit of employment on the basis of past, present, or future application for, or membership in, a uniformed service.[3] Under USERRA, discrimination occurs whenever uniformed service becomes the "motivating factor" in an employment decision, unless the employer can show that the same decision would have been made notwithstanding the uniformed service. USERRA also contains an anti-retaliation provision, which protects all employees who participate in the reporting, investigation or filing of claims of violations of USERRA, regardless of whether they themselves performed uniformed service.

USERRA grants employees broad reemployment rights when they have been absent from their jobs because of "service in the uniformed services." Specifically, USERRA protects employees who are honorably discharged and who return to their jobs following periods of uniformed services of no longer than five years. The five-year period is cumulative over the course of an employee's employment, although it can be extended under certain circumstances, such as situations in which an employee is ordered to or retained on active duty, because of war or national emergency declared by the President or Congress.

An employer will be excused from its reemployment obligations under USERRA when circumstances have changed during an employee's absence which make it "impossible or unreasonable" for the employer to rehire the employee following his or her uniformed service. For example, a bona fide reduction-in-force that eliminates the position held by an employee performing uniformed service could excuse an employer from its obligation to reemploy that employee. The "impossible or unreasonable" exception, however, is very limited and should not be applied without a thorough review and analysis of the situation.

USERRA allows employers to require returning employees to provide documentation of the length and character of their uniformed service to assist them in determining eligibility for reemployment and the timeliness of reemployment applications. When such documentation is unavailable to

returning employees, their employers must reemploy them until the documentation becomes available.

Under USERRA, employees who serve in the military for a period of more than six months may not be discharged without cause for one year following the date of reemployment. Employees who serve for between one and six months may not be discharged without cause for six months following the date of reemployment. Employees who serve for 30 days or less are given no protection from discharge without cause.

Highlights of the New USERRA Regulations

As discussed above, the DOL issued regulations effective January 18, 2006, intended to assist employers in addressing some of the most common issues raised by USERRA. The following discussion highlights many of the questions and the answers contained in the new regulations regarding coverage issues.

USERRA Coverage Issues

Individual supervisory liability for USERRA violations. Adopting the positions taken by some federal courts, the DOL has taken the position that, as the definition of employer under USERRA is much broader than that under federal employment discrimination statutes, individual supervisors may be considered to be employers liable under the Act for USERRA violations. As such, the DOL refused to exclude from its definition of employer individual supervisors and managers (20 CFR § 1002.5(d)).

"Military service need not be the only reason that an employee leaves his employment for it to be covered by USERRA. . ."

Employer's obligations in joint employer situations. The new regulations attempt to clarify the application of USERRA to employees with multiple, joint employers. For example, when two entities each exercise certain control over an employee's terms and conditions of employment, such as in the case of contract employees, then both entities are considered to be the "employer" and share responsibility for compliance under USERRA (20 CFR § 1002.37). The DOL, however, refused to adopt provisions similar to the Family Medical Leave Act regulations, which expressly allocate statutory responsibilities and liability between "primary" and "secondary" employers. Instead, the DOL indicated in its comments that in cases in which more than one entity is the employer, each entity's responsibility, status and liability as an employer under USERRA "is assessed by determining whether the entity controls the employee's employment opportunities, not by reference to shorthand labels such as "primary employer" and '"secondary employer."'

The regulations clarify, however, that employees with more than one employer are required to notify each employer of the upcoming leave to remain eligible for reemployment except when "military necessity" prevents such notice (20 CFR § 1002.85). Moreover, under USERRA, with certain exceptions, service members remain eligible for reemployment benefits only as long as their cumulative military service with the employer totals five years of service or less. When the employee is employed by more than one employer, the regulations provide that each employer must provide a separate and distinct five-year limit, even if those employers share responsibility for the terms and conditions of the employee's employment (20 CFR § 1002.101).

Reasons for absence covered by USERRA. Military service need not be the only reason that an employee leaves his employment for it to be covered by USERRA – provided that such service is at least one of the reasons. The DOL, while recognizing this issue, specifically declined to set guidelines or standards as to how much advance time an employee might need to prepare for a deployment, and refused to set specific guidelines as to when an employee must return to work following the cancellation of mobilization orders (20 CFR §§ 1002.1002.73-74).

Notice of leave. Normally, an employee or an appropriate military officer, must notify the employer that the employee intends to take a leave to perform military service. The employee's notice to the employer may be either verbal or written and does not need to follow any particular format. While the DOL strongly recommends that under normal circumstances the employer be provided at least 30 days prior notice, it does not adopt a specific notice standard and instead states that the notice should be as far in advance as is "reasonable under the circumstances." Moreover, the DOL has further indicated that in situations in which notice is prevented by "military necessity" or is otherwise impossible or unreasonable under the circumstances no notice is necessary. Only a military authority can make the determination to designate what constitutes "military necessity." Accordingly, in certain circumstances employees may not be required to provide advance notice to employers prior to undertaking military service (20 CFR § 10085-86).

Part 2 of this article will address benefits while on military leave, including health insurance, vacation, sick leave, and other nonseniority benefits; reemployment issues, including the employers obligation to provide prompt reemployment, the right to reinstatement, the escalator principle, and the retirement plan credit; litigation issues; and notice requirements. ■

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[1] "Service in the uniformed services" means the performance of duty on a voluntary or involuntary (drafted) basis, including active duty, active duty for training, initial active duty for training, inactive duty training, and full-time National Guard duty. It also includes time that an employee is absent from work for an examination to determine if he or she is fit for any of the above-referenced types of duty, and for funeral honors duty performed by members of the National Guard or Reserves. Note, however, that certain types of service in the National Disaster Medical System (NDMS) are considered service in the uniformed services for purposes of USERRA even though NDMS personnel are not in the uniformed services.

[2] *Final rule*, 70 FR 75246, December 19, 2005.

[3] There is no exclusion under USERRA for executive, managerial or professional employees. There is also no exclusion for temporary, part-time, probationary or seasonal employees. USERRA, however, does not apply to independent contractors.

Medicare

Revised NCD guidance includes new patient data requirements

by Katherine G. Geraghty, J.D., Contributing Editor

A revised guidance for national coverage determinations (NCDs), including, as a condition of payment, the development and capture of additional patient data to supplement standard claims data, known as "Coverage with Evidence Development" (CED), was released by CMS. CED was created to ensure that the care provided to beneficiaries meets Medicare coverage standards and conforms to the conditions stated in the NCD.

CMS drew a large number of public comments after it posted a draft version of the guidance document on April 7, 2005. The agency considered closely the comments it received in developing the revised guidance, particularly to those concerns raised by the public regarding the meaning and particular applications of CED. CMS also clarified the legal basis for incorporating CED into the national coverage process.

The CED process. CED, by collecting additional patient data as part of the coverage process, is expected to generate data on the utilization and impact of the item or service evaluated in the NCD so that CMS can document the appropriateness of the item or service under current coverage, consider future changes in coverage for the item or service, and generate clinical information that will improve the evidence base on which providers support their recommendations to Medicare. The CED process also may allow for coverage when a Medicare beneficiary is enrolled in a clinical study and the item or service would not otherwise be covered.

The guidance document describes the two types of CED requirements, including "Coverage with Appropriateness Determination" (CAD) and "Coverage with Study Participation" (CSP). The guidance document provides additional information regarding CED processes and requirements, including data sources, principles governing the application of CED, ending CED-required data collection, how researchers may access CMS' CED data, funding data collections to meet CED requirements, and other uses of data collected under CED.

CAD. CMS may require CAD as a condition of payment where there is adequate evidence to determine that an item or service is reasonable and necessary, but additional clinical data is needed that is not routinely available on claims forms to ensure that the item or service is being provided to appropriate patients in the manner described in the NCD. The CAD data supplements the information gathered routinely through claims for services rendered and is collected by providers when the service is provided. CAD will therefore be required by CMS if there is a concern that data collected on a claim form is insufficient to determine that the item or service was appropriately provided as outlined in the NCD.

Coverage with study participation. CSP will allow coverage of certain items or services for which the evidence is not adequate to support coverage and when additional data gathered in the context of clinical care would further clarify the impact of these items and services on the health of Medicare beneficiaries. In the past, this level of evidence would have prompted noncoverage decisions.

The CSP concept considers the item or service to be reasonable and necessary only while evidence is being developed, which includes research conducted on the outcomes, effectiveness, and appropriateness of health care services and procedures to identify the manner in which diseases, disorders, and other health conditions can be prevented, diagnosed, treated, and managed clinically. Evaluations of the comparative effects, health and functional capacity; alternative services and procedures utilized in preventing, diagnosing, treating, and clinically managing diseases, disorders, and other health conditions may also be evidence development. ■

CMS News, July 12, 2006.

Fraud and Abuse

Scully, DoJ resolve allegations of improper reimbursement for travel expenses

by Stacey Fahrner, J.D., M.P.H., Contributing Editor

Former CMS administrator, Thomas Scully, agreed to pay $9,782 to settle false claims allegations relating to his search for private employment during his term as administrator. The government claimed that he inappropriately obtained government reimbursement for certain personal travel expenses.

Specific instances. The government cites several instances in which Scully allegedly arranged government travel and sought reimbursement for travel expenses related to his employment search. Scully submitted a claim for reimbursement for expenditures related to official business for travel to a Washington D.C. law firm in which he participated in a meeting regarding possible employment. In addition, Scully sought reimbursement for trip to Atlanta, which he made under the guise of official business. According to the settlement agreement, Scully had a "perfunctory" meeting with CMS employees, after which he met with another law firm regarding potential employment. Scully claimed for reimbursement air fare, taxis, parking, meals, and incidentals amounting to $652.07.

In a more egregious example of Scully's behavior, the settlement claims that he was reimbursed in the amount of $1446.58 for travel expenses to California where he met with an investment firm. The settlement agreement alleges that he was only charged $67.07 for a single night in a hotel room.

Finally, the settlement agreement states that Scully obtained reimbursement for expenses related to a trip to Boston where he met with a law firm to discuss his employment. The government contends that Scully submitted an itinerary stating that the trip would last over 12 hours, which entitled him to reimbursement of meals and incidental expenses. His itinerary stated that he was visiting with CMS regional employees in the morning and speaking at a university in the afternoon. According to the settlement agreement, however, Scully never visited the CMS regional office. Instead, he met with the law firm throughout the morning and early afternoon before giving his speech and returning to Washington.

Scully's response. Scully maintained that he did not submit any improper claims for reimbursement to the government and disagreed with the government's characterization of the facts. Scully noted that he requested and obtained from the Secretary a waiver under 18 U.S.C. § 208, which allowed him to conduct his employment search while still serving as Administrator of CMS. He further asserted that any trips including both government and personal business were properly reimbursable by the government. ■

Settlement Agreement, July 6, 2006.

Antikickback

OIG OKs free clinic's practice of dispensing drugs on behalf of PAPs

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

In keeping with its past support of patient assistance programs (PAP), the Office of Inspector General (OIG) has recently offered a favorable opinion on a clinic's plan to dispense free drugs provided by pharmaceutical PAPs. Under the plan, a nonprofit, tax-exempt clinic would dispense drugs on behalf of patient assistance programs (PAPs) to financially needy patients, including some patients enrolled in Part D. According to the opinion, issued on June 30, 2006, the plan would not constitute grounds for the imposition of sanctions because it poses minimal risk to the integrity of the federal health care programs.

The clinic's proposal. The clinic generally obtains approximately 99 percent of its drug inventory from PAPs sponsored by pharmaceutical manufacturers. The free clinic would dispense drugs for two types of PAPs. In one arrangement, individual patients enrolled in the PAP would obtain their medications from the free clinic. The pharmaceutical manufacturer would be responsible for establishing eligibility criteria and enrolling patients.

In another arrangement, the free clinic would receive free drugs pursuant to an agreement with the manufacturer to dispense the drug to patients who meet the PAP's eligibility criteria. While the PAP would define the eligibility criteria, it would not enroll particular patients. The free clinic would be responsible for documenting patient eligibility before dispensing the drugs.

Under both arrangements, the free clinic would not receive any compensation for either the PAP or the PAP sponsor in connection with the administrative activities. No insurer would be billed for any part of the drugs dispensed through the program.

OIG's analysis. According to the OIG, the proposed arrangement would not constitute a vehicle to induce or reward referrals of federal health care program business from the clinic to any PAP sponsor because there is no apparent remuneration provided by the PAPs to the clinic and it does not bill patients or insurers for any items or services. In addition, the clinic is not in a position to generate business for any PAP sponsor that would be payable by a federal health care program. Finally, by dispensing drugs obtained though the PAPs to Medicare beneficiaries, the free clinic would not offer an impermissible inducement to the beneficiaries to generate business that would be payable by a federal health care program because although beneficiaries receive something of value in the form of free drugs, there is no corresponding opportunity for the clinic to influence these beneficiaries to obtain federally payable items and services. ■

OIG Advisory Opinion, No. 06-08, June 30, 2006, Health Care Compliance Reporter, ¶500,143.

Antikickback

Proposed EMS arrangement would not violate anti-kickback

by Gené Stephens, J.D., Contributing Editor

A municipality's proposed arrangement to provide emergency medical services through an ambulance service owned and operated by it would not generate prohibited remuneration under the anti-kickback statute because CMS allows for such municipal arrangements to reduce cost-sharing amounts of municipal residents, according to a June 26, 2006, Office of Inspector General (OIG) advisory opinion. Specifically, the proposed arrangement would allow a government owned ambulance provider to amend its current billing policies to treat the funding received from taxes as payment for otherwise applicable cost-sharing amounts due from residents of the municipality.

Cost-sharing arrangements. CMS allows municipalities to reduce cost-sharing amounts to its municipal residents who are unable to pay for medical services or who can only pay to the extent of their Medicare or other health insurance coverage. Under the proposed arrangement, an ambulance provider owned by the municipality would amend its current billing policies to treat the funding received from taxes in the area as payment for otherwise applicable cost-sharing amounts due from residents.

The CMS *Medicare Benefit Policy Manual* provides that a state or local government facility that reduces or waives its charges for patients unable to pay or that charges patients only to the extent of their Medicare and other health insurance coverage is not viewed as furnishing free services in violation of the Statute. The CMS provision applies only to situations in which a government unit is the ambulance supplier and, therefore, would apply to the proposed arrangement of the municipality. Because the municipality's proposed arrangement met CMS requirements, the Office of Inspector General would not impose civil monetary sanctions. ■

OIG Advisory Opinion, No. 06-07, June 26, 2006, Health Care Compliance Reporter, ¶500,142.

In the News

Odyssey settles fraud charges for $12.9 M

The U.S. Department of Justice announced on July 13, 2006, that Dallas based Odyssey Healthcare agreed to pay the government $12.9 million to settle allegations that the company submitted false claims to Medicare for services provided to hospice patients who were not terminally ill and, therefore, were ineligible for the Medicare hospice benefit. The settlement, which covers a period from 2001 to 2005, also resolves charges originally brought against Odyssey Healthcare by a former regional vice president. She will receive $2,326,500 for bringing the matter to the attention of the government. Odyssey HealthCare also has entered into a Corporate Integrity Agreement (CIA) with the HHS Office of Inspector General.

DoJ Press Release, July 13, 2006.

SEC moves forward on SOX improvements

In an attempt to improve the implementation of the Sarbanes-Oxley (SOX) investor protection law, the Securities and Exchange Commission (SEC) published a concept release as a prelude to its forthcoming guidance for management in assessing a company's internal controls for financial reporting. The concept release seeks feedback in four areas: identifying risks to financial statement account and disclosure accuracy; objectives of the evaluation procedures; factors management should consider to determine the nature, timing, and extent of its evaluation procedures; and documentation requirements. Following its May 10, 2006, Roundtable devoted to Section 404 implementation issues, the Commission issued a roadmap for improvements. The issuance of the concept release is one of the milestones on that roadmap, and it brings the SEC one step closer to issuing guidance for management that has been lacking since the law was enacted in 2002.

SEC Press Release, July 11, 2006.

High Court delines to hear clawback case

On Monday June 19, 2006, the Supreme Court of the United States declined to hear a case in which five states were seeking injunctive relief from the phased-down state contribution, commonly referred to as the clawback payments, established in the Medicare Modernization Act of 2003. The clawback payment refers to the states' monthly payment made to the federal government beginning in 2006 to defray a portion of the Medicare drug expenditures for full-benefit dual eligible individuals whose Medicaid drug coverage is assumed by Medicare Part D. Texas, Kentucky, Maine, Missouri, and New Jersey, asserted in the complaint that the payments violated state sovereignty. Arizona, Alaska, Connecticut, Kansas, Mississippi, New Hampshire, Ohio, Oklahoma, South Carolina, and Vermont, filed amicus briefs.

United States Supreme Court, Certiorari Summary Disposition, June 19, 2006, National Conference of State Legislatures Press Release, March 2006.

NY senate passes Medicaid fraud bill

Following a CMS report that called on New York to "do more to meet its program integrity obligations," the state senate on June 14, 2006, passed a bill to reduce Medicaid fraud and save tax payers and estimate $2 million. Attorney General Spitzer criticized the bill and stated that it "fails to enact the most important Medicaid reforms that will save taxpayer dollars." ■

Joseph Bruno, Majority Leader Press Release, June 14, 2006, Attorney General Spitzer Press Release, June 21, 2006.