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On The Front Lines 4

Part 2: What health care employers must know to comply with military leave laws by William P. Schurgin, Esq., and Amanda A. Sonneborn, Esq., Contributing Editors

Medicare 1

- IPPS FY 2007 final rule addresses quality, EMTALA, HwH, CAP

HIPAA 2

- Clinton bill would broaden scope of covered entity definition

Trends 3

- Benefits of price transparency explored

Health Information Technology 3

- House approves HIT bill

Fraud and Abuse 7

- Stark information technology exceptions announced
- CMS takes first steps to implement Medicaid Integrity Program

Administration 8

- Providers overcharged for discount drugs

In the News 8

Wolters Kluwer Law & Business

IPPS FY 2007 final rule addresses quality, EMTALA, HwH, CAP

In addition to the changes to the hospital inpatient prospective payment system (IPPS), a number of changes made by the Deficit Reduction Act of 2005 (DRA) promoting higher quality and more efficient care in hospitals have been included in the IPPS final rule for fiscal year (FY) 2007 issued by CMS on August 1, 2006.

Hospital quality data. The final rule implements a DRA provision that requires hospitals to report additional quality measures to receive an update in rates equal to the full market basket rate of increase. Hospitals that report quality data will receive the full market basket increase to their payment rates, while those hospitals that do not report quality data will receive 2.0 percentage points less than the market basket.

EMTALA changes. In addition, the final rule amends the regulations as recommended by the EMTALA Technical Adivsory Group (TAG), which was convened to review issues related to EMTALA and its implementation.

The EMTALA TAG was asked to consider: (1) whether there should be a federal requirement that all hospitals must have an emergency department; (2) whether EMTALA should be interpreted as meaning that all hospitals (including specialty hospitals) with specialized capabilities or facilities must accept appropriate transfers; and (3) whether specialty hospitals are exacerbating problems with "on-call" coverage for emergency departments.

Although CMS did not recommend to Congress that all hospitals must have an emergency department, it is requiring that all Medicare-participating hospitals with specialized capabilities, including specialty hospitals, accept appropriate transfers of unstable individuals, regardless of whether the hospital with specialized capabilities has an emergency department.

Additionally, CMS has modified the current requirement under which only a physician is authorized to determine that a pregnant woman having contractions is in false labor. Under the final rule, hospitals will be able to use certified nurse-midwives or other qualified nonphysicians acting within their scope of practice, as defined in hospital medical staff bylaws and state law, to make the determination.

Hospitals within hospitals. In the final rule, CMS has revised the regulations for grandfathered HwHs, grandfathered satellites of excluded hospitals, and grandfathered satellites of excluded units to allow these facilities to increase or decrease their square footage, or decrease their number of beds, without jeopardizing their grandfathered status. These changes could be undertaken for any reason and would not be limited to situations involving changes in federal, state, or local laws or catastrophic events. In addition, these changes would not be limited to cases in which a facility must be relocated.

Competitive acquisition program. In an interim final rule with comment (IFC) published last year, CMS required that sales of units of competitive

acquisition program (CAP) Part B drugs be excluded from the average sales price (ASP) calculation for the first three years of the CAP. Pharmaceutical manufacturers and the approved CAP vendor, however, raised the concern that this rule is unworkable and overly burdensome because there are certain circumstances in which a drug could be sold for CAP purposes but then be very difficult to track to determine if it was administered (e.g., in the case of a drug supplied under the CAP's emergency restocking provision).

Consequently, the final rule changes the definition of unit so that the method of counting units, for the first three years of the CAP, excludes units of CAP drugs that are sold to an approved CAP vendor for use under the CAP. ■

CMS Fact Sheet, Aug. 1, 2006.

HIPAA

Clinton bill would broaden scope of covered entity definition

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

Legislation that would establish consumer privacy protections, data security rules, and a comprehensive Privacy Bill of Rights was introduced by Senator Hillary Rodham Clinton (D-New York). Entitled the "Privacy Rights and OversighT for Electronic and Commercial Transactions Act of 2006" (PROTECT Act), the legislation is "about empowering consumers and giving them a say in how companies buy, sell and market their private data, while entitling them to effective security protections."

Clinton noted that according to the Privacy Rights Clearinghouse, since February 2005, almost 89 million Americans have had their most sensitive data exposed through theft, computer hacking, and simple negligence. Furthermore, identity theft remains one of the fastest growing crimes, according to the Federal Trade Commission. "We cannot stand by while Americans every day are seeing their most personal information compromised by lax and outdated privacy and security standards," Clinton said. "Consumers have the right to clear privacy standards and strong protections for their most sensitive information."

Privacy Bill of Rights. The bill enacts a Privacy Bill of Rights that establishes three consumer protections:

- people have the right to know, and to correct, information that is being kept about them;
- people have the right to know what is happening to their personal information when they are cooperating with a business and to make decisions about how it is used; and
- in a democracy, people have the right and the obligation to hold their government and the private sector to the highest standards of care with the information they gather.

Right to medical privacy. The bill requires the Secretary to modify the regulations promulgated under §264(c) of the Health Insurance Portability and Accountability Act to broaden the scope of who is considered to be a "covered entity." A covered entity must include those entities and individuals that disclose health information to other entities in the course of their commercial activities and not in relation to the provision of health care services. The bill also requires the Secretary to develop a procedure for reporting any unlawful disclosures of identifiable health information in violation of Social Security Act §§1176 or 1177.

Right to sue and seek damages for negligent data handlers. The bill creates a tiered system of damages to an injured individual. Although small businesses are exempt, to hold accountable businesses that are negligent in the handling of personal data, a for-profit entity is liable for $1,000 for breaches and $5,000 for actual misuse of information. This provision is in response to the small incentive that businesses currently have to protect personal data with a high level of security.

Right to full disclosure of data breach. Because many states do not require notification, many identity theft victims are unaware, even years later, that their information has been put at risk. Accordingly, the legislation requires that consumers be notified immediately if their credit or identity is compromised.

Other protections that the PROTECT Act provides for include a right to protect phone records, freeze personal credit, know when one's data leaves the U.S., and automatic free credit reports. ■

CCH Chicago Bureau, July 26, 2006.

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Trends

Benefits of price transparency explored

by Catherine Hubbard, Contributing Editor

Experts including academics, hospital representatives, and insurers gave testimony on the need for price transparency in health care during a meeting of the U.S. House Ways and Means Health Subcommittee on July 18, 2006.

In support of the need for increased transparency, Health Subcommittee Chairman Nancy Johnson (R-Conn) stressed the difficulty for most patients in understanding their medical bills and determining whether the prices are accurate. According to Johnson, health care is the only major sector of our economy in which consumers and providers have virtually no useful information on the true costs of medical goods and services. Greater health care price transparency has the potential to increase competition and create pressures to contain or reduce health care costs.

The July hearing follows a prior Subcommittee hearing in December 2005 that focused on a report by the Government Accountability Office (GAO) on price variations for health services within the Federal Employees Health Benefits Program. The GAO found significant price differences for hospital inpatient and physician services in different areas around the country. In addition, the report concluded that areas with the least competition among health care providers had higher prices compared to areas with more competition.

Regina Herzlinger, a Professor of Business Administration at Harvard Business School, Boston, Massachusetts, suggested that an independent agency could help to make prices reflect all publicly available information. She said that the Securities and Exchange Commission could serve as a model for the new federal body that would enforce standards for integrated and transparent prices. Consumers who use the information would redirect capital so that productive firms would be rewarded and unproductive firms would be penalized. In addition, information and competition would continually reduce transaction costs, she said.

Despite the hearing, the House on Wednesday, July 26, 2006, removed a provision that would have required hospitals to make public some price information from a health care information technology bill, according to the July 27, 2006, Kaiser Family Foundation Daily Health Policy Report. ■

CCH Washington Bureau, July 19, 2006, Committee on Ways and Means Advisory, July 11, 2006.

Health Information Technology

House approves HIT bill

by Catherine Hubbard, Contributing Editor

A health information technology bill that would provide for creation of an interoperable health information technology system was approved by the U.S. House of Representatives on July 27, 2006. The Health Information Technology Promotion Act (H.R. 4157), approved by a 270-148 vote, would require HHS to study how variation and commonality of state laws on patient health record security and confidentiality affect the flow of medical data. The department would have 18 months to send legislative recommendations to Congress, according to a bill summary.

In addition, the bill would:

- require that certain federal health information collection systems be capable of receiving information in a form consistent with any guidelines endorsed by a national coordinator within three years of endorsement;
- update diagnosis coding systems for the digital age and provide an expedited process for updating standards;
- promote commonality among state and federal security and confidentiality laws and regulations in order to protect the exchange of health information;
- ensure that providers that participate in Medicare, Medicaid and other federally funded health care programs will be able to maintain health information in electronic form;
- provide for studies and reports on the expansion of telehealth services; and
- provide safe harbors to anti-kickback civil and criminal penalties for the provision of health information technology and training services and an exception to the limitation on certain physician referrals (under Stark) for the provision of technology and training services to health care professionals;

continued on page 6

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On The Front Lines

Part 2: What health care employers must know to comply with military leave laws

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

This two part article addresses 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. Part I provided an overview of the Uniformed Services Employment and Reemployment Act of 1994 and the related regulations coverage issues. Part 2 highlights additional questions and the answers contained in the new regulations.

The Department of Labor (DOL) issued regulations effective January 18, 2006, to assist employers in addressing some of the most common issues raised by Uniformed Services Employment and Reemployment Act of 1994 (USERRA).[1] Health care employers, often impacted by reserve and national guard call ups because of the need for medical specialists, must be in compliance with these regulations. The following discussion addresses the new regulations as they relate to benefits while employees are on military leave, reemployment issues, litigation issues, and notice requirements.

Benefits while on military leave, when a leave begins

Health insurance. Under USERRA an employee called to service may elect to continue to participate in the employer's health insurance plan for up to 24 months. Similar to COBRA, for employees called to service for more than 30 days, employers have the right to require the employee to pay up to 102 percent of the full insurance premium for coverage. For employees called to service for 30 or fewer days, the employee cannot be required to pay more than the normal employee share of the premium. The new regulations clarify that employers may cancel health insurance coverage for employees on military leave if the employee departs for leave without electing to continue coverage (20 C.F.R. § 1002.165). The regulations also allow the employer to develop reasonable rules for canceling coverage for employees who opted to continue coverage, but who have failed to pay for the continued coverage (20 C.F.R. § 1002.167). The regulations, however, do provide for liberal reinstatement clauses that allow the service member to restore coverage in certain situations.

Vacation and other benefits. USERRA does not require employers to pay their employees regular pay while absent from their position, although some employers choose to do so. USERRA, however, does require employers to provide employees the same rights and benefits it provides to other employees on similar furloughs or leaves of absence.

Furthermore, USERRA requires employers to credit an employee's period of uniformed service as active employment for purposes of calculating the employee's "seniority and other rights and benefits determined by seniority." For nonseniority based benefits, USERRA requires an employer to provide employees on military leave with the same nonseniority benefits it would provide to nonservice members on furlough or leave of absence. As vacation is often earned based on an employee's length of seniority, some employees and employers were confused as to whether vacation was a seniority benefit. The new regulations clarify that vacation leave is a nonseniority benefit, and as such, the employer need only provide vacation benefits to an employee on military leave if it also provides those benefits to similarly situated employees on comparable leaves (20 C.F.R. § 1002.150(c)). With that said, however, employees returning from military leave are credited with the military services period for determining future vacation entitlement and accrual rates.

Although USERRA requires an employer to provide employees on military leave with the same nonseniority benefits and rights it would provide to nonservice members on furlough or leave of absence, it does not clarify what leaves of absence must be considered comparable to military leave. The new regulations attempt to clarify how an employer can determine whether the nonseniority benefits it provides employees on military leave are the same or better than an equivalent nonmilitary leave of absence (20 C.F.R. §§ 1002.149-150). The regulations

provide that the duration of the leave may be the most significant factor to consider when determining if leaves are comparable. For instance, a two-day funeral leave is not comparable to an extended military leave. Other factors to consider include the purpose of the leave and the ability of the employee to choose when to take the leave (20 C.F.R. § 1002.150). According to the DOL, whether the nonmilitary leave is paid or unpaid is irrelevant as to whether the leave should be considered comparable for purposes of determining what benefits to provide an employee on military leave.

The DOL, however, deliberately did not comment on whether certain nonseniority benefits that other laws provide for (e.g., those benefits required by the Family Medical Leave Act), rather than those benefits provided for by an employment contract or employer policy, must be provided to employees on military leave. As the DOL determined that the legislative history gave no "unambiguous indication" of what Congress intended as to whether legally required leave benefits for other comparable leaves must be applied to military leaves, it declined to comment on the issue other than to say such situations must be decided on a case by case basis.

Sick leave. Employees are permitted upon request to use any accrued vacation, annual or similar paid leave during the period of military service. An employer, however, cannot require them to do so. The new regulations further provide that while an employee generally is not entitled to use his or her sick leave while on military leave, an employee can use sick leave if the employer allows employees to use sick leave for any reason, or allows other similarly situated employees on comparable furlough or leave of absence to use accrued paid sick leave (20 C.F.R. § 1002.153).

"Employers must not consider an applicant's military service in making a decision not to hire an employee."

Reemployment issues

Right to seek alternate employment before engaging in reemployment with the pre-service employer. Under USERRA, returning service members, depending upon the length of the military service, can have an "application period" as long as 90 days to apply for reemployment with their preservice employer. Some returning service members have used that period to try jobs with other employers before applying for reemployment. Although the proposed regulations initially blessed this practice, in response to employer comments expressing concern that such a broad-based policy may allow returning service members to violate various employment policies, including policies prohibiting employees from working for competitors, the DOL revised the rule. As amended, the returning service member retains wide latitude to seek alternate employment during the "application period," so long as that alternate employment does not violate the employer's policy (20 C.F.R. § 1002.120). Thus, for example, if an employer forbids employees from moonlighting for direct competitors, a returning service member who violates that policy by working for a competitor before seeking reemployment could be subject to discipline or even termination.

Employer's obligation to provide prompt reemployment. USERRA requires that employers provide for the prompt reemployment of returning service members who request it. The regulations clarify that as a general rule, an employer shall reinstate the employee as soon as practicable under the circumstances. Reinstatement must occur within two weeks after the employee applies for reemployment "absent unusual circumstances" (20 C.F.R. § 1002.181).

Right to reinstatement and the escalator principle. One of the hallmarks of USERRA is its reemployment provisions, and in particular, the application of the escalator principle, which requires the employer to reemploy service members in the positions they would have held if they had not served in the military. Not only does this provision apply to promotional opportunities for which the employee may have been eligible, it also applies to salary increases. When these increases or promotions are subject to the employee's passing a test or exam, an employee that returns from military leave must be provided an opportunity to take the missed exam and receive the increase. The regulations address the factors an employer should consider in the timing of a "make-up" exam, including but not limited to the length of time the employee was away from work on military leave, duties and responsibilities of the reemployment position, and the nature of responsibilities of the service member while he or she was in the service (20 C.F.R. § 1002.193).

The regulations also provide further clarification as to whether and when to apply the escalator principle to merit pay increases. In particular, when determining whether an increase would have been attained with "reasonable certainty" and, thus, be subject to the escalator principle, employers may consider the employee's work history, history of merit increases, and the work and pay history of other employees in the same or similar positions (20 C.F.R. § 1002.236).

Retirement plan credit. An employee who is reemployed after military leave is entitled to have his or her benefits under any retirement plan (including nonqualified plans) determined as if the leave had not occurred. If a retirement plan

is contributory, such as a 401(k) plan, the employee's entitled to make up contributions missed during military leave. The regulations clarify the manner in which retirement benefits must be restored and require that the employer make any additional contributions to a plan within 90 days after reemployment, except for contributions that are contingent upon employee contributions (20 C.F.R. § 1002.262).

Litigation issues

Burden of proof in USERRA discrimination cases. An individual alleging discrimination and/or retaliation under USERRA bears the initial burden of proving that one of the reasons for the alleged discrimination and/or retaliation was his or her USERRA-protected status or USERRA-protected activities. If the individual is able to show that military status or otherwise protected activities were a reason for the alleged action, the burden shifts to the employer, who must then prove as an affirmative defense that it would have taken the same action even if the employee was not protected by USERRA (20 C.F.R. §§ 1002.22-23).

Statute of limitations for USERRA claims. USERRA has no express statute of limitations. The DOL regulations recognize that an unreasonable delay by a claimant in asserting his or her rights under USERRA that prejudices an employer may result in the claim's dismissal under the doctrine of laches (20 C.F.R. § 1002.311). The DOL rejected the contrary position taken by at least one federal court that the four year general federal statute of limitations period provided for in 28 U.S.C. § 1658 applies. Thus, employers cannot assume that claims older than four years are time-barred.

Interview issues

The new regulations establish that employers may ask applicants about his or her military service or obligations. The DOL issued this guidance recognizing that many employers find military service an attractive attribute of a prospective employee. Employers, however, must not consider an applicant's military service in making a decision not to hire an employee.

USERRA Notice Revisions

Employers must provide employees with notice of their rights under USERRA. The DOL also released final regulations relative to the USERRA notice requirements under the Veterans Benefits Improvement Act of 2004 (VBIA) and updated its notice of rights posting language. The primary change is an acknowledgement in the USERRA notice that certain types of service in the National Disaster Medical System are protected by USERRA, and the creation of separate notices for federal and nonfederal employees. The new notice requirements take effect January 18, 2006. A copy of the VBIA notice regulations and amended notice can be found at http://www.dol.gov/vets/regs/fedreg/final/2005023960.pdf. A poster form of the new notice can be found at www.dol.gov/elaws/userra.htm.

Conclusion

Overall, USERRA provides broad protection to employees who perform uniformed services. health care employers should examine their current leave policies and practices to determine their compliance with the law and the new regulations. health care employers also should review and revise each of their employee benefit plans to comply with USERRA's requirements. Bear in mind that individual states may require employers to provide greater rights and benefits to their employees on military leave than USERRA requires. Further, employers can always be more generous, for example, by continuing group health plan coverage at active rates.

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

HIPAA (cont.)

According to Health Subcommittee Chairman Nancy Johnson (R-Conn.), "this critical legislation will improve health care quality for all Americans, significantly reduce preventable medical errors, and rein in rising health care costs. America's health care system has lagged way behind other sectors in adopting information systems, and it remains locked in an era of paper and pencil."

Several Democrats opposed the bill, saying it "could jeopardize the privacy of medical records for millions of patients and does little to improve the current use of information technology in the health care field," according to a press release from House Ways and Means Ranking Member Charles Rangel (D-New York). Rangel co-wrote a bill that is similar to the Senate bill (S 1418) but offered additional privacy protections. ■

CCH Washington Bureau, July 27, 2006.

Stark information technology exceptions announced

On Tuesday August 1, 2006, CMS released the much anticipated final rule outlining exceptions for electronic prescribing and electronic health records to the physician self-referral law, or Stark law. The exception should help promote the adoption of electronic health records and e-prescribing, an important part of the Bush administration's health agenda. According to the administration, tis new technology will improve efficiency, reduce medical errors, improve quality of care, and provide better information for patients and physicians.

The Stark law prohibits a physician from making referrals for certain "designated health services" (DHS) payable by Medicare to an entity with which the physician (or an immediate family member of the physician) has a financial relationship, unless an exception applies. Because the donation of electronic prescribing technology may create a financial relationship that is subject to the Stark prohibition, the Medicare Modernization Act of 2003 (MMA) directed the Secretary, in consultation with the Attorney General, to create an exception to the physician self-referral prohibition to permit certain entities to provide non-monetary assistance to physicians to encourage their use of electronic prescribing technology.

The final rule sets forth the terms and conditions of the MMA-mandated physician self-referral electronic prescribing exception and also sets forth the conditions for a new regulatory exception for arrangements involving the donation of electronic health records software or information technology and training services.

To qualify for the physician self-referral exception regarding donations of electronic prescribing technology and training services, both the donor and recipient must meet certain criteria as set forth in 42 C.F.R. §411.357(v). For example, the arrangement must be in writing, the donation cannot be a condition of doing business with the donor, the donor cannot limit or restrict the compatibility of the technology, and the donated items or services are of the type that can be used for any patient without regard to payor status.

Similarly, the exception for electronic health records, set forth in 42 C.F.R. §411.357(w), requires for example that the software and training services must be necessary and used predominantly to create, maintain, transmit, or receive electronic health records; the software is interoperable; and the donation is not based on the value or volume of referrals.

The MMA mandated a similar safe harbor under the anti-kickback statute for donations of electronic prescribing technology made to physicians and certain other entities. The Office of Inspector General (OIG) is simultaneously issuing a final rule regarding the MMA-mandated anti-kickback statute safe harbor for certain electronic prescribing arrangements, as well as a safe harbor for the donation of electronic health records software or information technology and training services.

CMS Fact Sheet, Aug. 1, 2006.

CMS takes first steps to implement Medicaid Integrity Program

by Michelle Oxman, J.D., Contributing Editor

CMS has released a comprehensive plan for implementation of the Medicaid integrity program (MIP) required by the Deficit Reduction Act of 2005 (DRA). According to CMS Administrator Mark McClellan, "Together with our state partners, we are implementing unprecedented steps to assure that Medicaid funds do not support criminal activities within the system."

Under the MIP, CMS will: (1) conduct audits of providers by private contractors to be selected by competitive bidding; (2) provide technical assistance to and oversight of state fraud control efforts; (3) collaborate with state Medicaid agencies, state and federal law enforcement agencies, providers and other stakeholders to assess the vulnerabilities of the Medicaid program and develop best practices for state enforcement and recovery efforts; and (4) offer research and detection components to identify developing fraud trends through data mining. The DRA required CMS to hire 100 additional employees to implement the program.

New organizational structure. A new unit, the Medicaid Integrity Group (MIG), will be located in the Center for Medicaid State Operations. MIG will include the MIG Director's office, responsible for the audit and review of providers. It will coordinate the activities of field staff, hold national training conferences and prepare the annual report to Congress.

In addition, the Division of Medicaid Integrity Contracting will develop requests for proposals and administer the contracts with the Medicaid Integrity Contractors (MICs). The Division of Fraud Research and Detection will conduct data mining to identify new trends in Medicaid fraud and abuse. The Division of Field Operations will have five teams located in the five areas of considered "fraud hot spots,": (1) Southern California; (2) South Florida; (3) New England, New York and New Jersey; (4) Chicago to Detroit; and (5) the Gulf Coast. Seventy-nine of the 100 positions are allocated to the Division of Field Operations. Twenty will be assigned to the Office of Financial Management to work on existing fraud and abuse programs.

Strategies for success. The initial comprehensive plan states that the MIP will emphasize consultation and collaboration with all stakeholders, including state and federal law enforcement agencies, state fraud control units, the HHS Office of Inspector General, and providers who are aware of new developments in fraud and abuse. The MIG will develop best practices for auditing and review based on its experience and that of the other parties. It emphasizes flexibility in order to adapt to the "ever-changing nature" of fraud and abuse.

The appropriation for fiscal year (FY) 2006 was $5 million for start-up costs. As the program develops, funding will increase to $75 million by FY 2009. ■

CMS Release, July 18, 2006; Comprehensive Medicaid Integrity Plan of the Medicaid Integrity Program, FY 2006-2010, July 1, 2006.

Administration

Providers overcharged for discount drugs

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

According to a review of the 340B drug pricing program by the Office of Evaluations and Inspections (OEI), inadequate oversight of the program by the Health Resources and Services Administration (HRSA) lead to overpayments approaching $4 million in June 2005 alone. Because manufacturer pricing data is confidential, participating providers rely on HRSA monitoring to ensure that they receive the prices to which they are entitled.

The 340B pricing program allows participating providers to obtain drugs from manufacturers at or below the statutorily defined prices, known as the 340B ceiling prices. Manufacturers are responsible for calculating the ceiling prices and ensuring that participating providers are charged at or below the ceiling prices. The ceiling prices are roughly equal to the average manufacturer price reduced by the unit rebate amount.

Findings. According to the study, the largest overpayments resulted from inappropriate handling of negative ceiling prices, which occur when a drug's unit rebate amount is less than the average manufacturer price. Manufacturers should charge only a penny per unit in such situations; however, the study showed that many entities were paying anywhere from $1.65 to $1,931 per unit. The study also showed that higher rates of overpayments were associated with low volume entities, manufacturers, and wholesalers. Finally, the study concluded that HRSA's data regarding unit of measure and package size were inconsistent and, therefore, resulted in inaccurate ceiling prices. Specifically, HRSA's ability to identify overpayments would be compromised if it relied on existing data.

OEI suggested that HRSA improve its oversight of the 340B program, provide technical assistance to all entities participating in the program, publish guidance regarding the penny price policy, and obtain consistent data on drug unit of measurement and package size. ■

OIG Report, No. OEI-05-02-00073, July 1, 2006, Health Care Compliance Reporter, ¶530,442.

In the News

CCHIT announces first products certified for EHR

Twenty two amulatory electronic health record (EHR) products achieved the Certification Commission for Healthcare Information Technology (CCHIT) certified status after undergoing inspections that demonstrated their compliance with CCHIT's published criteria, according to an announcement by HHS Secretary Michael Leavitt on July 18, 2006, and a CCHIT announcement on July 31, 2006. HHS awarded CCHIT a three-year contract in September 2005 to develop and evaluate criteria and an inspection process leading to certification of the first ambulatory (office- and clinic-based) EHRs, followed by inpatient (hospital) EHRs and networks over which they interoperate. The certification criteria have been designed to ensure that products provide a broad foundation of functionality, will evolve to be interoperable with other systems, and include security features that protect the privacy of personal health information. To be certified, a product must comply with 100 percent of the CCHIT criteria. Inspections are continuing, with additional results to be announced at the end of July and quarterly thereafter. A complete list of certified products is at www.cchit.org.

CCHIT News Releases, July 18, 2006 and July 31, 2006.

CMS earmarks funds to transform Medicaid

States will receive $150 million over 2007 and 2008 to fund research and design of ways to transform their Medicaid systems to increase quality and efficiency of care, according to Mark B. McClellan, CMS Administrator. Funds for the Medicaid "transformation grants" were authorized by the Deficit Reduction Act of 2005 (DRA) and are aimed at state adoption of innovative systems to get more value out of the money they spend on Medicaid. All states will be eligible for a grant and grant amounts will be variable dependent upon the number of states that apply. Greater use of community-based long-term care services and increased flexibility afforded by the DRA will lead to further efficiencies and slower growth for the future of the Medicaid program.

CMS Public Affairs News Release, July 21, 2006.

Gov's order protects against balance billing

An executive order to protect insured Californians from being charged for medical expenses that they do not owe has been signed by California Governor Arnold Schwarzenegger. The executive order guards against "balance billing," a practice that makes patients responsible for paying the disputed difference between their provider's bill and their health plan's coverage. The Executive Order directs the state Department of Managed Health Care to (1) take all necessary steps to protect Californians from balance billing, including fully enforcing existing regulations and developing new regulations if necessary; (2) increase efforts to enforce the Knox-Keene Health Care Service Plan Act of 1975 (which sets forth the requirements that health care plans must follow); (3) review the criteria used by health plans to determine the value of noncontracted medical services to make sure that providers are reimbursed fairly; and (4) implement a fair, fast, inexpensive and independent dispute resolution process for providers that will resolve reimbursement disagreements and ensure that providers are reimbursed for their services.

Office of the Governor Press Release, July 25, 2006.