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New IRS directive on electronic health record subsidies raises many questions

by Hilary Goehausen, Contributing Editor

The Internal Revenue Service's (IRS') recent directive on electronic health record (EHR) subsidies continues to raise questions. During a teleconference sponsored by the American Health Lawyers Association, an IRS official clarified that, if in the course of a field examination, an IRS agent finds private benefit or inurement outside the context of an EHR, the agent could look into the benefits of the health information technology (HIT) as well. Participants in the teleconference also explored disclosure, cost-sharing, and other issues.

New directive. In May, the IRS released a directive explaining that it will not treat the benefits that a hospital provides to its medical staff physicians as impermissible private benefit or inurement in violation of Internal Revenue Code (Code) §501(c)(3) if the benefit falls within the range of HIT Items and Services allowed by HHS' EHR regulations, and the hospital operates in accordance with the conditions set forth in the IRS directive. Lois Lerner, IRS director, Exempt Organizations, indicated in May that "taxable hospitals are already doing this." She added that "tax-exempt hospitals were concerned that there may be a concern from our end with regard [to these benefits] and exemption."

EHR arrangements are not like writing a check to doctors, Linda Moroney, an attorney with Drinker Biddle Gardner Carton in Milwaukee, Wisconsin commented during the teleconference. According to Moroney, physicians using an EHR arrangement don't have anything to walk away with at the end of the day; just something they can access at the time the service is provided to the hospital. Therefore, there is no accretion to wealth under Code §61. Alternatively, EHR subsidies may qualify as a fringe benefit not taxable to participating physicians under Code §132, Moroney indicated.

Excess benefit transaction. While Moroney conceded that it is entirely possible that an EHR subsidy could qualify as an excess benefit transaction (EBT), an IRS official from the Exempt Organizations Technical Division clarified that if the parties meet the conditions described in the IRS directive, the IRS would not consider the subsidy or cost-sharing to be an EBT that would trigger excise taxes. If in the course of a field examination, however, an IRS agent finds private benefit or inurement outside the context of an EHR, the agent could look into the benefits of the HIT as well. The IRS official also clarified that an EHR arrangement would not be treated as an EBT simply because a physician utilizing the subsidy is on the hospital board or is otherwise considered to be a "disqualified person."

Shared access. Participants in the teleconference also addressed the extent to which physicians must provide the hospital with access to their patients' EHRs. According to the IRS, hospitals should have some level of access to patient records because an EHR arrangement that is subsidized for the benefit of participating physicians, but gives the hospital no access, could constitute an impermissible private benefit or inurement in violation of Code §501(c)(3).

Cost sharing. Participants also addressed cost-sharing issues raised by the IRS directive. According to the IRS, physicians would need to pay their share of costs for an EHR arrangement prior to receiving the benefit. Otherwise, this may be viewed as reimbursement for expenses and monetary remuneration.The IRS stipulated, however, that the directive allows hospitals to vary the allocation of costs between the hospital and participating physicians. The directive mandates that, at a minimum, 15 percent of the costs be paid by physicians, but permits for different allocations among different groups of physicians.

Possible limitations. According to Moroney, a hospital could limit the subsidy to a certain level of physicians, such as "active" medical staff. Marilyn Lamar, an attorney with Liss & Lamar in Oak Brook, Illinois, noted that a hospital could provide the subsidy to a group practice that includes some physicians not on the hospital's medical staff without running afoul of the IRS directive and HHS regulations. Lamar also indicated that it maybe possible to provide the EHR subsidy to physicians not on the hospital's medical staff as long as the community rationale is followed. ■

CCH Washington Bureau, Aug. 17, 2007.

Quality of Care

Medicare stops payment for treatment of hospital-acquired infections, preventable errors

by Matthew Mann, J.D., Contributing Editor

As part of its fiscal year (FY) 2008 inpatient prospective payment system (IPPS) *Final rule* (72 FR 47568, August 22, 2007) CMS implemented § 5001(c) of the Deficit Reduction Act of 2005 (PubLNo 109-171) (DRA), which takes initial steps toward preventing Medicare from paying additional costs associated with treating hospital-acquired conditions during a hospital stay. Specifically, the rule identifies eight conditions, including three serious preventable events labeled "never events" that CMS, in conjunction with the Centers for Disease Control and Prevention (CDC), identified as meeting the statutory criteria established in the DRA.

Complications such as infections and other preventable errors can lead to higher Medicare payments in two ways. First, higher reimbursement can result from outlier payments generated when the treatment of a complication increases the cost or length of stay for a beneficiary. In addition, under the Medicare Severity-DRG reforms CMS adopted in the FY 2008 IPPS *Final rule*, 258 sets of DRGs are split into two or three subgroups based on the presence or absence of a complication or comorbid condition (CC) or major CC. If a condition acquired during a beneficiary's hospital stay is on the CC or major CC list, it could potentially result in a higher payment to the hospital.

CMS worked in conjunction with public health and infectious disease experts at the CDC to select the conditions that comprise the CC and major CC lists. Comments were solicited from the public regarding conditions proposed initially in the FY 2007 IPPS *Proposed rule* (71 FR 23996, April 25, 2006) and later summarized in the FY 2007 IPPS *Final rule* (71 FR 47870, August 18, 2006). The conditions were then assessed using criteria set forth in the DRA. The DRA requires the HHS Secretary to select at least 2 conditions that are: (1) high cost or high volume or both; (2) assigned to a higher paying DRG when present as a secondary diagnosis; and (3) reasonably preventable through application of evidence-based guidelines. The DRA allows the list of conditions to be adjusted over time, but it must always contain at least two conditions that have been assessed using the above criteria.

The hospital-acquired infections for which payment will be withheld beginning October 1, 2008, are certain catheter-associated urinary tract infections, vascular catheter-associated infections, and mediastinitis after coronary artery bypass graft surgery. The preventable errors or "never events" include pressure ulcers, leaving an object in a patient's body dur-

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ing surgery, providing incompatible blood or blood products, air embolism as a result of surgery, and hospital falls. Cases involving these eight conditions will not be paid at a higher rate unless they were present on admission (POA) beginning in FY 2009. The POA indicator is required for CMS to determine which of the selected conditions developed during a hospital stay. The DRA requires hospitals to begin reporting the secondary diagnoses that are POA for patients effective for discharges on or after October 1, 2007, a year before any reduction in payments will go into effect.

In addition to eliminating reimbursement for these conditions, the CMS regulations include protections to ensure that hospitals do not (1) avoid patients perceived to be at risk for infections, or (2) bill patients for payments withheld by Medicare. CMS will only select those conditions that are "reasonably preventable"; thus, if hospital personnel are engaging in good medical practice, the additional costs of a hospital-acquired condition will be avoided in most cases and the risk of selectively avoiding patients at high risk of complications will be minimized. ■

Final rule, 72 FR 47568, Aug. 22, 2007.

Assess jurisdiction in *qui tam* FCA cases on a claim-by-claim basis, court concludes

by Matthew Mann, J.D., Contributing Editor

Seven claims of fraud in a relator's complaint alleging ten distinct claims of False Claims Act (FCA) violations by a Medicare and Medicaid provider must be evaluated on a case-by-case basis to determine jurisdiction, according to the Court of Appeals for the Tenth Circuit. The federal district court in New Mexico had improperly dismissed all of the claims in the *qui tam* complaint because three of the ten fraud claims alleged by the relator were "based upon" information contained in prior publicly disclosed complaints and the relator was not the "original source" of the disclosures in the prior actions, the court said.

Process for determining jurisdiction. Federal courts engage in a two-step inquiry to determine if jurisdiction over *qui tam* actions is proper. First, a court determines if the relator's action is based upon a preexisting public disclosure of wrongdoing. If so, the court must determine if the relator is the original source of the information. If the relator is not the original source of the information, the court must dismiss the case for lack of subject matter jurisdiction. Only cases brought by the relator who originally exposed the deception may be heard in federal court, so as to prevent cases from subsequent relators who may try to capitalize on the original source's efforts.

Appellate court's reasoning. On appeal, the Tenth Circuit agreed that jurisdiction was lacking for three of the ten fraud claims in the relator's complaint but disagreed with the district court that the dismissal of three claims spoils the whole pleading. In the Tenth Circuit's view, a court must ask whether the public disclosure bar applies to each reasonably discrete claim of fraud. The Tenth Circuit relied on *Rockwell Int'l Corp. v. U.S.*, a recent Supreme Court decision in which the inverse situation had arisen.

In *Rockwell*, the relator asserted that jurisdiction with respect to one claim provided the court with jurisdiction over all of his claims. The Supreme Court rejected the relator's argument, quoting the Third Circuit decision by then-Judge Alito, which concluded that "[t]he plaintiff's decision to join all of his or her claims in a single lawsuit should not rescue claims that would have been doomed ... if they had been asserted in a separate action. And likewise, this joinder should not result in the dismissal of claims that would have otherwise survived."

Based on the reasoning in *Rockwell*, the Tenth Circuit concluded that when deciding whether federal jurisdiction is proper in *qui tam* cases alleging violations of the FCA, the court must perform a claim-by-claim assessment. Therefore, the court remanded the case back to the district court to determine if the remaining seven claims in the relator's complaint survive jurisdictional scrutiny when viewed individually. ■

Boothe, U.S. ex rel. v. Sun Healthcare Group, Inc., 10th Cir., No. 06-2156, Aug. 7, 2007, Health Care Compliance Reporter ¶800,363.

IRS proposed 990 requires substantial disclosure

by Cynthia F. Reaves, J.D., Contributing Editor

On June 14, 2007, the Internal Revenue Service (IRS) released a discussion draft of the redesigned Form 990, the annual information return filed by tax-exempt organizations. The release of the redesigned Form 990 represents the most significant revision of the form since 1979. The IRS has requested public comments on the draft Form 990 by September 14, 2007, with the intention to have the redesigned form available for the 2008 tax year (i.e., forms filed in 2009).

The redesigned Form 990 retains a similar fundamental approach as its predecessor; however, the inquiries are more comprehensive. In this regard, the form is broken into parts: a core report, common to all exempt organizations; and several schedules that apply to certain organizations based upon their operations and exempt purpose. The IRS noted that the redesign of Form 990 was based on three guiding principles: (1) enhancing transparency by providing the IRS a realistic picture of the organization and its operations, along with a basis for comparison to similar entities; (2) promoting tax compliance by accurately reflecting the organization's operations and use of assets so that the IRS may efficiently assess the risk of noncompliance; and (3) minimizing the burden on the filing organization by asking questions in a manner that makes it relatively easy to complete the form while not imposing unwarranted burdens in recording and documenting the information.

The core Form 990

The redesigned Form 990 consists of a ten-page core form, including a summary page. Depending upon the responses to the inquiries set forth in this core form, the filing organization may be required to complete one or more schedules. The summary page is intended to provide the IRS with a snapshot of the operations and expenditures of the exempt filing entity and provide a ready basis for comparison to other exempt organizations. In particular, the summary requests information on the organization's: (a) activities and governance; (b) revenues; (c) expenditures; (d) net assets or fund balance; and (e) gaming and fundraising activities. Importantly, the summary allows the IRS to quickly identify areas of interest or for further review, as each line in the summary is sourced to a specific section of the core form.

Including the summary, the core form is divided into ten parts, with the remaining nine parts focusing on specific areas. Part II of the core form sets forth inquiries relating to compensation and other financial arrangements between the exempt organization and its officers, directors, trustees, key and highly compensated employees and independent contractors. A significant change from the prior Form 990 is the request that the filing organization report not only with respect to relationships with current employees and contractors, but also with respect to former employees and contractors. The reporting organizations must provide additional information for these highly compensated individuals, including details on loans, deferred compensation, fringe benefits, and retirement. A new question asks whether the organization has paid for first class travel, club dues, or use of a personal residence for these individuals.

Part III of the core form is new and sets forth inquiries regarding the composition of the exempt entity's board or governing body, as well as questions regarding its governance and financial statement practices. Finally, the section discusses the means by which the organization is accountable to the public by making certain governance information publicly available. The areas of inquiry tie together prior IRS communications regarding conflict of interest policies, public access to organization documents and filings and independent audit committees. Exempt organizations would do well to keep in mind the significance of the representations called for in these disclosures and confirm the existence and legal compliance of the documents that are the subject of the reporting requirement and underlying representations.

Parts IV, V and VI of the core portion of the redesigned Form 990 mirror the current reporting requirements of earlier versions of the Form 990. The sections set forth the layout for reporting of revenues, expenses, and balance sheet items. Significantly, the inquiry is very detailed and includes specific questions about certain revenue streams, such as Medicare/Medicaid payment lines for health care providers. Schedule D to the redesigned Form 990 contains a compilation of various financial statement attachments that are sourced to these portions of the form. In this regard, the proposed change places all the required supplemental financial information from Parts I, VII and VIII of the redesigned Form 990 into a separate schedule. The redesigned financial statement reporting requires additional reporting of actual and contingent federal tax liabilities, and other amounts that are not necessarily reported on an organization's balance sheet (such as museum collections, conservation easements, and escrows held for the benefit of others).

Parts VII and VIII of the core Form 990 set forth questions related to the filing organization's general activities and its compliance with various IRS filing requirements. Several

of the questions refer the filing organization to a particular schedule for additional information. The questions delve into whether the filing organization is engaged in joint venture activities as well as certain other specific activities, such as the provision of debt counseling services, the maintenance of art collections or the issuance of exempt bonds. Several of these areas have received heightened IRS scrutiny in recent years.

Part IX of the core form requests statements regarding program and service accomplishment for the exempt organization. The filing organization is asked to set forth any significant changes in its activities or methods of conducting activities. In addition, the organization is asked to identify its three largest program services as measured by expenses incurred. The core form requests direct revenue and, for 501(c)(3), 501(c)(4), and 4947(a)(1) trusts, related program service expenses. This aspect of the redesigned Form 990 presents an opportunity for a filing organization to emphasize its accomplishments related to its exempt purposes.

The final section of the core form, Part X, is the signature block where an authorized officer of the filing organization attests to the correctness and completeness of the Form 990.

Redesigned Form 990 schedules

The redesigned Form 990 has fifteen attached schedules compared to the two schedules contained in the prior version of the Form 990. Not all schedules apply to all filing organizations, but several of them are likely to apply to a majority of the filing organizations. The subject matter of the fifteen schedules are:

- Schedule A: Supplementary Information for Organizations Exempt Under Section 501(c)(3)
- Schedule B: Schedule of Contributors
- Schedule C: Political Campaign and Lobbying Activities
- Schedule D: Supplemental Financial Statements
- Schedule E: Private Schools
- Schedule F: Statement of Activities Outside the U.S.
- Schedule G: Supplemental Information Regarding Activities
- Schedule H: Hospitals
- Schedule I: Supplemental Information on Grants and Other Assistance to Organizations, Governments and Individuals in the U.S.
- Schedule J: Supplemental Compensation Information
- Schedule K: Supplemental Information on Tax-Exempt Bonds
- Schedule L: Supplemental Information on Loans
- Schedule M: Non-Cash Contributions
- Schedule N: Liquidation, Termination, Dissolution, or Significant Disposition of Assets
- Schedule R: Related Organizations

Schedule A is one schedule that is likely to be widely used because it is required to be filed by all 501(c)(3) organizations that are public charities. The schedule focuses on public charity status by asking for very detailed information to help the IRS determine whether an organization is, indeed, a public charity. The areas of inquiry include information about compensation of independent contractors and highly compensated employees, specified activities posing compliance concerns, the basis for an entity's public charity status, and transactions and relationships with noncharitable exempt organizations. It is interesting to note that the IRS is considering using this schedule to issue definitive rulings as an alternative to Form 8734 (Schedule for Advance Ruling Period, filed at completion of 5-year advance ruling period).

Schedule D must be completed by all organizations that file a Form 990. The schedule contains a compilation of various financial statement attachments, many of that were required on the prior version of the Form 990. The schedule ties back to the core form and is intended to elaborate upon the filing organization's responses set forth therein. The IRS' position is that by compiling the attachments into a single schedule there will be an improvement and standardization of reporting for this information.

It is likely that many larger charities will be required to complete Schedule G to the redesigned Form 990. The schedule must be completed by organizations that (1) have gross income of $10,000 or more from fund raising events, or (2) enter $10,000 or more in expenses arising from certain fees, such as professional fund raising fees. In requiring the completion of this schedule, the IRS noted that while gaming and fund raising continue to be vital to the economic well-being of many tax-exempt organizations, there continue to be areas of noncompliance related to such activities. Specifically, the IRS noted a lack of transparency concerning how much of each donated dollar is provided to the charity for its charitable work.

Schedule H is of particular interest due to the increased scrutiny that health care organizations have experienced in recent years. The schedule is new and must be completed by organizations that operate a facility that provides hospital or medical care. The IRS noted recent concerns regarding whether there are differences between for-profit and tax-exempt hospitals with respect to the inquiries set forth on the schedule. The proposed schedule was intended to combat the perceived lack of transparency surrounding the activities of exempt organizations that provide hospital or medical care. In drafting the schedule, the IRS attempted to quantify the community benefit standard applicable to tax-exempt organizations, basing the schedule on the Catholic Health Association's community benefit reporting model. The new schedule increases the reporting burdens of exempt health care organizations. In particular, critics have noted that it will be difficult for exempt organizations to quantify accurately the community benefit that an organization provides. For example, it has been noted that the IRS excludes inquiries that relate to community development initiatives that larger health care organizations may undertake from time to time to extend their community

benefit, such as economic development, public advocacy for underserved communities and other initiatives.

Overall, the redesign of the IRS Form 990 will increase the amount of information that is available to the IRS about exempt organizations. Furthermore, it will encourage the leaders of such organizations to gather information and scrutinize their organization's operations and activities in much greater detail than in prior years in anticipation of filing their Form 990 return. Such heightened scrutiny is likely to trigger important operational changes for some exempt organizations. To the extent that this information allows the IRS to identify with greater ease instances of noncompliance, the revised Form 990 will be of great benefit.

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HHS, DOJ collaborate to target infusion therapy fraud

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

A two-year demonstration project focusing on preventing infusion therapy providers operating in South Florida from committing Medicare fraud has been undertaken by HHS with the support of the Department of Justice (DOJ), according to HHS Secretary Michael Leavitt. The project seeks to develop and demonstrate improved methods for the investigation and prosecution of fraud occurring among infusion providers. The underlying purpose of the project is to stop fraud before it happens, CMS Acting Deputy Administrator Herb Kuhn explained in a press conference on August 20, 2007.

Fraud scheme. The South Florida Medicare infusion therapy scam was identified because the billing was "out of whack" with other areas of the country, Kim Brandt of the CMS Office of Program Integrity explained. In 2004, Florida had fewer reported AIDS cases than California and New York, yet its total submitted Medicare charges for these cases was three times higher than California and five times higher than New York. In addition, the number of infusion services billed in Florida tripled from 2004 to 2005, jumping from 4.3 percent to 15 percent of national billing. The average cost of infusion therapy in the state was $16,389 per treatment, while the average cost in California was $3,932 per treatment, and in New York was $1,935 per treatment.

The fraud scheme began when for-profit clinics and doctors recruited HIV/AIDS patients by paying them to come to clinics and receive nonrendered or medically unnecessary infusion services, which were then billed to Medicare at clinically unbelievable frequencies and toxic dosages. The scheme involved (1) billing for fictitious patients; (2) billing for unbelievable dosages; (3) billing for the appropriate drug but administering saline solution to the beneficiary; and (4) duplicate billing. In 2006 and 2007, the U.S. Attorney's Office for the Southern District of Florida filed 20 criminal cases against 42 defendants for infusion clinic fraud in South Florida.

CMS' new procedures. CMS will require infusion providers that operate in several South Florida counties to resubmit applications to be a qualified Medicare infusion therapy provider. Any provider that fails to reapply within 30 days of receiving notice will have its Medicare billing privileges revoked. In addition, infusion therapy providers that fail to report a change in ownership; have owners, partners, directors, or managing employees who have committed a felony; or no longer meet each and every provider enrollment requirement will have their billing privileges revoked. Infusion providers that successfully complete the reapplication process may be subject to an enhanced review, including on site visits, based on risk assessment.

CMS also will issue Medicare Summary Notices to beneficiaries in South Florida on a monthly basis instead of a quarterly basis, allowing beneficiaries more frequent access to their billing records. In addition, CMS and the DOJ hope to prevent providers who are committing fraud from migrating to other areas to avoid detection. To achieve this goal, the demonstration will expand to other Florida locales that CMS and federal law enforcement designate as high risk.

Prosecution of wrongdoers. R. Alexander Acosta, U.S. Attorney for the Southern District of Florida, agreed that fraud prevention was the most important object, but added that wrongdoers must be prosecuted. The DOJ is supporting HHS' new controls through an increase in prosecutions for health care fraud in South Florida. In May, the DOJ and HHS announced the work of a multi-agency team of federal, state, and local investigators, known as the Medicare Fraud Strike Force, designed specifically to combat Medicare fraud through the use of real-time analysis of Medicare billing. The Strike Force supplements the ongoing health care fraud enforcement efforts of the U.S. Attorney's Office for the area."Through real-time access to Medicare billing data, the Strike Force has allowed us to move quickly to make arrests and bring prosecutions as rapidly as possible," Attorney General Alberto Gonzales stated. Since implementing the "phase one" Strike Force in Miami last March, DOJ prosecutors and Assistant U.S. Attorneys from the Southern District of Florida have filed 47 indictments charging 65 individuals or entities with health care fraud in schemes that collectively billed Medicare more than $345 million.

State initiatives. Florida has implemented steps to control fraudulent activities, including joint federal and state site visits, prepayment edits and automatic denial of clinically unbelievable dosages, payment suspensions, provider enrollment onsite visits, enrollment revocations and deactivations, data analysis, prepayment review, and other activities. Corrective actions from these steps have resulted in denial of fraudulent and medically unnecessary Medicare infusion claims with charges in excess of $1.8 billion in 2005 and 2006. ■

HHS Press Conference, HHS Press Release, HHS Fact Sheet, Aug. 20, 2007.

States vary on HIE privacy, security solutions

by Valerie L. Witmer, J.D., Contributing Editor

States varied on several key aspects of health information exchange (HIE) plan implementation, according to a set of reports released by HHS' Agency for Healthcare Research and Quality (AHRQ). The reports, entitled "Privacy and Security Solutions for Interoperable Health Information Exchange," reviewed 34 state and territory HIE plans to "better understand what policies and practices need to be in place within and across states to both protect health information and promote nationwide electronic health information exchange."

Project overview. AHRQ's privacy and security project arose from findings in a June 2005 HHS report entitled "Summary of Nationwide Health Information Network Request for Information Responses," which contained responses from 512 organizations and individuals. Nearly every response cited the importance of patient privacy and noted concerns that attempts to implement nationwide electronic HIE might be thwarted by inconsistent interpretations and applications of the Health Insurance Portability and Accountability Act (HIPAA) privacy and security rules among organizations, as well as inconsistencies between HIPAA and state privacy laws.

The purpose of the AHRQ project was to address those concerns by "assess[ing] variations in organization-level business practices, policies, and state laws that affect electronic health information exchange" and identifying solutions that will "permit interoperability while preserving the necessary privacy and security requirements set by the local community."

The work reflected in the report was conducted by the Health Information Security and Privacy Collaboration, which consists of 33 states and Puerto Rico ("state teams"). Each state team identified a steering committee to provide leadership throughout the project. The committees were composed of leaders from state government and stakeholder organizations, including:

- providers;
- payers;
- federal health facilities;
- state government;
- pharmacies;
- long-term care facilities and nursing homes;
- professional associates and societies;
- medical and public health schools that undertake research;
- hospitals;
- public health agencies;
- community clinics and health centers;
- laboratories;
- home care and hospice facilities;
- correctional facilities;
- quality improvement organizations; and
- consumers or consumer organizations.

Key assumptions. All state teams participating in the project followed a standard core methodology but were allowed to tailor the process to meet their needs. They used 18 scenarios as the starting point for discussions of nine "domains" of privacy and security: user and entity authentication; authorization and access control; patient and provider identification; transmission security; information protection; information audits; administrative and physical safeguards; state law; and use and disclosure policy. According to the reports, the methodology developed for the project was based on three key assumptions: (1) decisions about how to protect the privacy and security of health information should be made at the local community level; (2) states must engage in discussions to develop an understanding of the variations between organizations within each state and across states; and (3) stakeholders at the state and community levels must be involved in identifying current variations, understanding the rationale underlying current business practices, identifying privacy and security requirements, and developing practical solutions.

Findings. According to the AHRQ reports, all 34 state teams had some type of HIE activity underway. Those activities ranged from isolated health information technology efforts conducted by single organizations, to implementation of multi-organizational HIE efforts, to early planning of statewide HIE efforts, to operating statewide HIE plans. Fifteen state teams had (1) identified and established a central body to coordinate HIE development; (2) appointed a board of directors; (3) established operating committees; and (4) completed a strategic plan. Seven states had established early implementation by (1) undertaking some of the key strategic plan implementation steps; (2) selecting a technology vendor; and (3) implementing HIE pilots. Only two states had a fully functioning statewide HIE plan.

Some of the report's key findings revealed a need for additional research and guidance on:

- identifying different interpretations of the HIPAA privacy rule among states;
- addressing variations between federal and state privacy laws;
- evaluating the technologies available to protect individuals' security and privacy;
- evaluating administrative processes and liabilities;
- developing a system that accurately and consistently matches individual patients with their health record information; and
- developing a standard set of definitions and terms — *e.g.*, "medical emergency," "current treatment," "related entity," and "minimum necessary" — to facilitate sharing of health information.

"These reports address one of the greatest concerns that Americans have about health information technology: Will their personal data be safe?" AHRQ Director Carolyn M. Clancy, M.D., said. "This work presents information on how to develop privacy and security solutions that allow for the exchange of information safely and securely."

Robert Kolodner, M.D., National Coordinator for Health Information Technology, emphasized, "Work at the state and local levels is integral to our success. The number of stakeholders involved in this initiative demonstrates the magnitude of this work." He added, "The report findings and recommendations will provide ongoing guidance for local, state, and federal governments as we move toward greater interoperability." ■

HHS Press Release, Aug. 1, 2007; Agency for Healthcare Research and Quality, Privacy and Security Solutions for Interoperable Health Information Exchange, July 1, 2007.

Medicare

CBO says budget deficit closing, but predicts health care spending will rise

by Stephen K. Cooper, Contributing Editor

The federal budget is on an unsustainable fiscal path, largely due to increasing health care expenditures in the Medicare and Medicaid programs over the next 10 years, the Congressional Budget Office (CBO) announced on August 23, 2007. The nonpartisan agency released its annual report, "The Budget and Economic Outlook: An Update," that shows the federal budget deficit at $158 billion – or roughly $90 billion below the deficit number for 2006.

CBO Director Peter Orszag told reporters that the lower deficit figure is attributable to strong but diminishing corporate tax revenues coupled with an unanticipated increase in individual tax revenues. Slower federal spending also contributed to closing the deficit, Orszag said. Sluggish economic growth and the current instability in the national housing market are unlikely to have an impact on the federal budget outlook, the CBO report said. The CBO noted that the cost of the wars in Iraq and Afghanistan contributed to the deficit, but that war spending was partially offset by lower-than-expected outlays from earlier appropriations.

Orszag said the federal budget would see a small surplus from higher tax revenues if tax cuts passed in President Bush's first term are allowed to expire after 2010. The CBO report projected that revenues from corporate income taxes will peak in 2007 at 2.7 percent of gross domestic product (GDP) and then gradually diminish. Most of the continued rise in tax revenues, as a percentage of GDP, will come from individual taxes, Orszag said.

The CBO report notes that the 2007 increase in individual income tax receipts is due partly to solid growth in wage and salary income and partly to rapid growth in nonwage income. For the most part, they appear to reflect underlying economic events that are unrelated to recent changes in fiscal policy, the report states. ■

CCH Washington Bureau, Aug. 23, 2007.

In the News

CMS demonstration targets post-acute care payment models

CMS announced the start of participant recruitment for the Post Acute Care Payment Reform Demonstration (PAC-PRD). The demonstration project was mandated by Congress in the Deficit Reduction Act of 2005. Participating providers include acute care hospitals, long-term care hospitals, inpatient rehabilitation facilities, skilled nursing facilities, and home health agencies. The key goal of this project is to generate recommendations for improving payment models based on data collected in the demonstration. CMS currently is attempting to recruit providers to participate in the demonstration project and is aiming to recruit a sample that is representative of the range of post-acute service providers across the country. The goals of payment reform include aligning incentives among the PAC settings with a particular focus on patient populations seen in more than one PAC setting.

CMS Press Release, Aug. 21, 2007.

HHA final rule encourages quality of care

The home health prospective payment system *Final rule* for calendar year (CY) 2008 reflects CMS' ongoing efforts to support beneficiary access to home health services and improve the quality and efficiency of care provided to Medicare beneficiaries through more accurate payments for services rendered, according to a CMS press release. For CY 2008, CMS plans to evaluate home health quality of care by using home health agencies' (HHAs') submission of Outcome and Assessment Information Set data. HHAs that submit quality data as required under current regulations will receive payments based on the full home health market basket update of 3.0 percent for CY 2008. For HHAs that do not report quality data, the market basket percentage increase will be reduced by 2.0 percentage points and the HHAs will only receive a 1.0 percent update for CY 2008.

CMS Press Release, Aug. 22, 2007.

Billing company owner pleads guilty to fraud

The owner of a South Florida Medicare billing company has agreed to plead guilty to conspiracy to commit health care fraud and submission of false claims for HIV medication and services. From October 2002 through April 2006, the billing company owner billed Medicare on behalf of approximately 75 Miami-based health clinics that purported to provide HIV infusion services to Medicare eligible beneficiaries. According to the charges, the clinics would provide the owner with bills for HIV treatments and services in amounts that the owner knew were medically impossible, in exchange for a fee of approximately five percent of all claims paid by Medicare. The prosecution resulted from the establishment of the Medicare Fraud Strike Force, a multi-agency team in South Florida designed to combat Medicare fraud in the region.

DOJ News Release, Aug. 20, 2007.