# HB 1905, HD2

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| Measure Title: | RELATING TO HUMAN SERVICES. |
| Report Title: | Department of Human Services; General Assistance Appropriations |
| Description: | Allows the Department of Human Services to draw from other funds appropriated to the Department of Human Services in the event the General Assistance appropriation is insufficient to meet General Assistance benefits payments. (HB1905 HD2) |
| Companion: | |
| Package: | None |
| Current Referral: | HMS, WAM |
| Introducer(s): | MIZUNO |

NEIL ABERCROMBIE
GOVERNOR

PATRICIA McMANAMAN.
DIRECTOR

BARBARA A. YAMASHITA
DEPUTY DIRECTOR

STATE OF HAWAII
DEPARTMENT OF HUMAN SERVICES
P. O. Box 339
Honolulu, Hawaii 96809-0339

March 20, 2012

**MEMORANDUM**

TO: The Honorable Suzanne Chun Oakland, Chair
Senate Committee on Human Services

FROM: Patricia McManaman, Director

SUBJECT: **H.B. 1905, H.D. 2, Proposed S.D. 1 - RELATING TO HUMAN SERVICES**

Hearing: Tuesday, March 20, 2012, 1:45 p.m.
Room 016, State Capitol

**PURPOSE:** The purposes of this bill are: Part I - to allow the Department of Human Services (DHS) to draw from other funds appropriated to DHS in the event the General Assistance (HMS 204) appropriation is insufficient to meet General Assistance benefits payments; Part II – appropriate funding to various organizations for health and social services; Part III – appropriate funding for positions to administer the supplemental nutrition assistance program in the DHS; Part IV - to require financial institutions to report suspected financial abuse to the appropriate police department and the DHS under specified conditions; Part V – establish the Hawaii Interagency Council on Homelessness; Part VI – allow the DHS to post on its website information on the National Human trafficking Resource Center hotline and poster; Part VII – establishing a human trafficking task force within the DHS; Part VIII – to allow community care foster family homes six months to find another Medicaid client upon the departure of their current Medicaid client and reducing the substitute caregivers from twenty-one years

and older to eighteen years and older; and Part IX – require the DHS to collaborate with various providers to revise the methodology for determining the level of acuity for Medicaid nursing home residents and setting reimbursement rates and working with the Department of Health to develop a referral and discharge plan based on acuity levels.

**DEPARTMENT'S POSITION:** The Department of Human Services (DHS) supports Parts I and V of this bill which contain language from Administration proposals. DHS opposes Parts II, III, IV as currently written, and VI, VII, VIII and IX of this bill.

The DHS strongly supports Part I of this bill which would allow the Department of Human Services (DHS) to draw from other funds appropriated to DHS in the event the General Assistance (HMS 204) appropriation is insufficient to meet General Assistance benefits payments. The general assistance program (HMS 204), pursuant to section 346-53(b), Hawaii Revised Statutes, is a block grant program. The maximum allowance a general assistance recipient may receive is determined by dividing the amount of the appropriation by the number of general assistance recipients. The DHS must adjust GA payments to remain within the GA appropriation when the caseload increases or decreases.

For fiscal year 2012, the payment level began at $353, but due to caseload increases the benefit payment amount was reduced to $319 in October 2011 and must be reduced further to $275 in April 2012 to remain within the authorized appropriation. In prior years, payment had been reduced to as low as $234 as caseloads increased. These reductions and fluctuations provide no stability to households who already live below poverty levels. Stopping the benefit payment or reducing the amount of the benefit payment for these individuals poses a real threat to the individuals' health and safety. It is also almost certain to trigger increased homelessness.

The DHS has requested an emergency appropriation for the current fiscal year to maintain the benefit amount at $319 per month. To reduce the future need to request emergency appropriations for the GA program, the Department proposes to utilize, when needed, savings from other programs. This bill would allow the DHS to use savings in other programs of the Department to fund the shortfalls in the GA program due to caseload fluctuations.

The Department of Human Services strongly supports Part V, Section 24 of this bill which would establish the Hawaii Interagency Council on Homelessness by statute.

Governor Abercrombie established the Hawaii Interagency Council on Homelessness (HICH) through issuance of Executive Order No. 11-21 on July 19, 2011. In establishing the HICH, the Governor of Hawaii found it to be imperative and in the public interest to capitalize on the opportunities and momentum generated by the United States Interagency Council on Homelessness (USICH). Mirroring USICH, the HICH provides leadership for the prevention and elimination of homelessness and works to ensure care for homeless persons in the spirit of the Law of the Splintered Paddle (Ke Kānāwai Mamalohoe).

Establishing the HICH in statute will enhance its ability to provide solutions for ending homelessness in Hawaii. The HICH has convened on several occasions and also developed investigative committees. These committees explore the current state of homelessness, the State and Counties responses to homelessness, and the collective efforts made by government, non-profits, business, and others to find solutions to homelessness. While there is clearly much more work that needs to be done, progress is being made. For example, the HICH-driven draft State Plan to end homelessness is currently being disseminated via internet and being discussed in venues across the State for public input/feedback (meetings being held March 16-30, 2012). The establishment

of the HICH by statute will ensure continued progress and accountability toward measuring outcomes and implementing solutions to homelessness.

The DHS is opposed to the proposed amendments in Part IV of this bill which would require financial institutions to report suspected financial abuse to the appropriate police department and the DHS under specified conditions. The language in S. B. 2314, S. D. 2, is preferred which adds financial exploitation of an elder as a crime to Chapter 708, HRS, and amends §412:3-114.5, HRS, to require financial institutions to report suspected financial abuse to the appropriate local law enforcement agency and not to the DHS. With the creation of a new criminal offenses pertaining to financial exploitation of an elder in Chapter 708, HRS, suspected financial abuse should be reported by financial institutions directly to the local law enforcement agency for criminal investigations.

We also note that the proposed criminal provisions as well as the language contained in S.B. 2314, S.D. 2 relating to DHS received very strong support from the community. The DHS is, frankly, baffled by this proposal which is inconsistent with testimony previously provided by the DHS, law enforcement, and other members of the community on S.B. 2314, S.D. 2.

The DHS does not have direct legal authority to seek judicial authorization to seize documents, freeze accounts or take other measures to immediately secure financial assets that may be at risk. Additionally, the DHS is without trained staff who have the expertise to review the complex financial records and transactions for the financial abuse cases identified by financial institutions.

The DHS does not conduct criminal investigations, nor does it prosecute crimes. The appropriate entity to receive reports of suspected financial abuse from financial institutions is a local law enforcement agency which has investigators and legal

remedies at its disposal to immediately stop access to a "vulnerable elder's" financial accounts when warranted.

The definition for "financial abuse" in §412:3-114.5, HRS, should be amended to include a reference to the newly created offenses In Chapter 708, HRS, of "financial exploitation of an elder" to read as follows:

**""Financial abuse" means financial [~~abuse or economic~~] exploitation[~~.~~] <u>of an elder as described in section 708- .</u>"**

The DHS appreciates the intent of Part II of this bill to appropriate finding to various organizations and Part III which would appropriate positions to DHS for the supplemental nutrition assistance program but must respectfully oppose the proposed appropriations which are beyond the priorities in the Executive Supplemental Budget. We request that the Legislature support the Executive Supplemental Budget.

The DHS opposes Part VII of this bill which would establish a human trafficking task force within the DHS to develop a comprehensive plan for human trafficking survivors. This bill would place demands on the Department that could not be met with our limited resources without substantial additional funding for the administration of the task force including staffing, outreach, and program development. Additionally, we note that the Department of Attorney General has a history of strong expertise and leadership in this arena as demonstrated by previous task forces on human trafficking which they led. Their history and familiarity with the topic, the provider community, and the intricacies of the law will be a valuable asset.

The DHS also strongly opposes Part VIII of this bill to allow community care foster family homes six months to find another Medicaid client upon the departure of their current Medicaid client and reducing the substitute caregivers from twenty-one years and older to eighteen years and older.

Section 30, of Part VIII which would amend §346-332, HRS, pertaining to community care foster family homes (CCFFHs) to allow a CCFFH at least six months to find a Medicaid client when their only Medicaid client has departed the home is unnecessary. To date, there have been no CCFFH closures as a result of the home not having a Medicaid client in residence. The CCFFH operator is given information on how to contact the various case management agencies to obtain Medicaid client referrals. As long as the CCFFH operator can document a good faith effort to locate a suitable Medicaid client in a timely manner, the CCFFH will not be closed or cited as having violated home certification requirements. We have, in fact, extended licenses in excess of one year when the circumstances so warranted.

In addition, requiring a physician to certify that the removal of a private-pay client may cause the client to sustain transfer trauma is not necessary and will create additional work for the CCFFH operator, case managers, and physicians.

The DHS recommends that §346-332, HRS, be repealed in its entirety because the demonstration project referred to in subsection (a) is no longer in existence and the term "community care foster family home" is already defined in §346-331, HRS, as a home providing twenty-four-hour living accommodations, including personal care and homemaker services, for not more than two adults at any one time, at least one of whom shall be a Medicaid recipient. This means that the CCFFH is required to have a Medicaid recipient in residence at any given time.

Section 31 of Part VIII would amend §346-334(b), HRS, to lower the substitute caregiver requirement age for CCFFH. The substitute caregiver must assume all of the duties and responsibilities of the primary caregiver when the primary caregiver, who is required to be at least age twenty-one, is absent from the home. The workload involved in providing care and supervision for three residents who are at the nursing facility level

of care increases at least 50% when compared with the care and supervision of only two residents in the home. The additional tasks and responsibilities associated with caring for three residents require that the caregiver possess the experience and maturity to complete the necessary tasks in a competent manner. Therefore, the minimum age of twenty-one should remain as the standard for both the primary caregiver as well as for all substitute caregivers.

Part IX of this bill would require the DHS to collaborate with various providers to revise the methodology for determining the level of acuity for Medicaid nursing home residents and setting reimbursement rates and working with the Department of Health to develop a referral and discharge plan based on acuity levels. Medicaid already reimburses nursing facilities on an acuity basis. Those facilities that care for more complex patients receive higher reimbursement. The acuity determination methodology is based on data reported by nursing facilities to the Centers for Medicare & Medicaid Services (CMS) and utilizes a CMS adopted methodology for calculating acuity. If the nursing facility providers in Hawaii would like to modify this methodology, DHS would be willing to work with them.

Thank you for the opportunity to provide testimony on this bill.

**HAWAII MEDICAL ASSOCIATION**
1360 S. Beretania Street, Suite 200, Honolulu, Hawaii 96814
Phone (808) 536-7702 Fax (808) 528-2376 www.hmaonline.net

TO: COMMITTEE ON HUMAN SERVICES
Senator Suzanne Chun Oakland, Chair
Senator Les Ihara, Jr., Vice Chair

DATE: Tuesday, March 20, 2012
TIME: 1:45 pm
PLACE: Conference Room 016

From: Hawaii Medical Association
Dr. Roger Kimura, MD, President
Linda Rasmussen, MD, Legislative Co-Chair
Dr. Joseph Zobian, MD, Legislative Co-Chair
Dr. Christopher Flanders, DO, Executive Director
Lauren Zirbel, Community and Government Relations

Re: HB 1905, HD2 Proposed SD1 RELATING TO HUMAN SERVICES.

In Support

Chairs & Committee Members:

Hawaii Medical Association supports this measure and would like to very respectfully ask for an addition to this measure in the spirit of funding necessary human services and ensuring access to medical care for pregnant women and children.

The HMA agrees that Medicaid is the cornerstone of health care for the most needy individuals in Hawaii. It is in the public interest to ensure that health care payments made with state funds or controlled by the State are sufficient to cover the actual costs of care. Inadequate reimbursement from Medicaid has compromised access to medical care because Hawaii has a high percentage of independent physicians who have no other means of making ends meet than by ensuring that the payments that they receive cover the cost of the services they provide.

As documented in numerous media reports, the inadequacy of medical care services, especially in specialty-care coverage in rural areas and on the neighbor islands, has reached a critical level. Hawaii's physicians serving Medicaid□eligible persons have been adversely affected by the inadequacy of Medicaid reimbursements and as a result there is a severe access to care crisis for the Medicaid population. This measure will go a long way to help serve Hawaii's most needy patients.

Due to the shortage of funds currently available HMA is amenable to the proposed changes attached, which were drafted by Med QUEST Director Kenny Fink. These changes relate only to creating parity in reimbursement increases for SCHIP. SCHIP covers pregnant women and children. HMA believes that they should be given the same access to care as other Medicaid recipients.

Thank you for the opportunity to provide this testimony.

THE SENATE S.B. NO. 2120

TWENTY-SIXTH LEGISLATURE, 2012 S.D. 1

STATE OF HAWAII

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A BILL FOR AN ACT

RELATING TO HEALTH.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF HAWAII:

SECTION 1. The legislature finds that medicaid is the cornerstone of health care for the most needy within Hawaii. Furthermore, the legislature has previously recognized that it is in the public interest to ensure that health care payments made with state funds or controlled by the State are sufficient to cover the actual costs of care. However, inadequate payment and reimbursement from medicaid have compromised access to medical care not only for the uninsured and those covered by medicaid but also for individuals who are covered by private employer-based health insurance.

As documented in numerous media reports, the inadequacy of medical care services, especially in specialty-care coverage in rural areas and on the neighbor islands, has reached a critical level. Furthermore, Hawaii's physicians serving medicaideligible persons have been adversely affected by the inadequacy of medicaid reimbursements and payments.

For a two year period beginning January 1, 2013, the Affordable Care Act (ACA) mandates that states reimburse primary care providers at 100% of Medicare rates for primary care services provided to Medicaid recipients. This increased reimbursement will be 100% federally funded. However, under the ACA, reimbursement for primary care services provided to Children's

Health Insurance Program (CHIP) recipients, namely children and pregnant women, will not be increased.

The purpose of this Act is to increase the payment for primary care physician services ~~for~~ provided to children and pregnant women covered under CHIP to be equal to such reimbursement provided to Medicaid recipients. ~~medicaid-eligible persons, including fee-for-service and QUEST-eligible individuals, and the QUEST-expanded care, and State Children's Health Insurance Pprogram (SCHIP).~~

Comment [1]: kfink 3/12/12 4:09 PM
Note that reimbursement for services provided to non-pregnant COFA adults will not be increased.

SECTION 2. There is appropriated out of the general revenues of the State of Hawaii the sum of $ ~~———~~2,800,000 or so much thereof as may be necessary for fiscal year 2012-2013 to increase payments for primary care services provided by primary care physician ~~services~~s for the care of ~~medicaid-eligible persons~~children and pregnant women who are enrolled in the Children's Health Insurance Program., ~~including fee-for-service, QUEST-physician services, and the QUEST-expanded care, and SCHIP program.~~

The sum appropriated shall be expended by the department of human services for the purposes of this Act; provided that:

(1) The sum is equitably distributed ~~between~~among the fee-for-service, QUEST and QUEST Expanded Access ~~medicaid-fee-for-service-physician-services and~~ health plans based on enrollment of CHIP recipients~~that provide QUEST-physician services, including the QUEST-expanded care program,~~, so that ~~the health plans~~payment ~~can increase the payment~~ for these physician services can be increased; and

(2) The sum, when added to the amount of reimbursement payable under the appropriate medicaid fee schedule, shall in no event exceed 100 per cent of the appropriate medicare fee schedule applicable to Hawaii.

SECTION 3. The department of human services shall include in its budget request for each year of the 2013-2015 fiscal biennium a sum at least equal to the sum appropriated in section 2, in addition to its baseline ~~medicaid~~ request for HMS 401, that will allow for increased moneys to

be paid out for primary care services provided by primary care physicians to CHIP recipients. ~~services for medicaid eligible persons, including fee-for-service and QUEST physician services, including the QUEST expanded access, and SCHIP program.~~ The department shall report the amount of the baseline medicaid sum and the additional funds to be paid out for physician services to the legislature no later than twenty days prior to the convening of the regular sessions of 2013 and 2014.

~~SECTION 4. The department of human services shall report to the legislature no later than twenty days prior to the convening of the regular sessions of 2013 and 2014 the amount of funding necessary to:~~

~~(1) Continue the increased payments for physician services up to 100 per cent of the appropriate medicare fee schedule applicable to Hawaii; and~~

~~(2) Increase payments up to 100 per cent of the appropriate medicare fee schedule applicable to Hawaii to all medicaid fee-for-service and QUEST providers, including the QUEST expanded care program, if approved.~~

SECTION ~~5~~4. This Act shall take effect on July 1, 2050.

# Susannah Wesley Community Center



March 19, 2012

TO: Senator David Ige, Chair
Members of the Senate Ways and Means Committee

FROM: Ronald Higashi, Executive Director
Susannah Wesley Community Center

SUBJECT: Support of the inclusion of an appropriation of the Youth Services Center In HB 1905 SD1 Proposed

My name is Ronald Higashi. I am the Executive Director of Susannah Wesley Community Center. Susannah Wesley Community Center has been providing services to youth and families in the Kalihi community for over a century.

I support the inclusion of the Youth Service Centers in HB 1905 SD1 proposed. To quote a section from the Office of Youth Services Statue, HRS Section 352D-4: Establishment; purpose.

*".... The office of youth services is established to provide services and programs for youth at risk under one umbrella agency in order to facilitate optimum service delivery, to prevent delinquency, and to reduce the incidence of recidivism among juveniles through the provision of prevention, rehabilitation, and treatment services."*

The Youth Service Centers formed the focus: HRS Section 352D-7: Youth Service Centers; creation. The Youth Service Centers would develop and implement programs in delinquency prevention; alternatives to the juvenile justice system; and system of coordinated juvenile justice and on juvenile justice services in order to reduce overlap and gaps in services.

I was fortunate enough to be on the "working committee" that published the "Youth Service Centers Project Development Report" after the statue was adopted. This further refined the Youth Service concept with more a detailed Operational Program and Architectural Program. The report emphasized the importance of it being a community-based culturally sensitive operation that empowers its particular community. The study also outlined alternative organizational structures that the Youth Service Center could adopt.

The Office of Youth Service Strategic Plan 2008-2013 further emphasis a community-centered approach to Youth Services.

*"Children grow up in the context of families and communities, not in isolated programs and classrooms – or as the African proverb goes, "it takes a village to raise a child". Thus, to nurture our youth to be resilient, productive, and contributing members of their community, it will take a range of services, supports, and opportunities from families, communities, institutions, and organizations."*

As the economy recovers, it is my hope that funding for the Youth Service Centers be yet again available to provide the necessary resources to the youth and families of our various communities.

If you have any questions or need more information, please feel free to contact me.

1117 Kaili Street • Honolulu, Hawaii 96819-3432 • (808) 847-1535 • FAX (808) 847-0787
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Susannah Wesley Community Center

Comments for Youth at Susannah Wesley Community Center to Support HB 1905SD1

TO: Senator David Y. Ige, Chair
Senator Michelle N. Kidani, Vice Chair
Members of the Senate Committee on Ways and Means

FROM: A sampling of Youth Participants of Susannah Wesley Community Center

DATE: March 19, 2012

RE: In Support of HB1905SD1, Making an Appropriation for Youth Service Centers

Tristan, age 13- I like it here because I like playing basket ball and I hope to join their Late Night Team. I come here because I can meet up with friends who don't go to same school as me. If Susannah Wesley was not here, I would just go home and sleep.

Ethan, age 11- Susannah's is a place that feels safe with the building and the staff always looking out for the little kids.

Jun Jun, age 10- I get homework helps and do lots of stuff. We play all kine games, pool, I have practiced shooting baskets, I get to sit and draw with contests.

Hershel, age 12- Here I learn and work on reading and math, it's getting more easy. Easy.

Arleth, age 16- I started coming here after school for activities its better than just hang out on the streets of Kalihi. Susannah Wesley helps me in school, I gain leadership skills. Without the center I would probably be hanging out with bad people, staying out late you know being a bad teenager.

Melvin, age 15- The center is a place to chill and hangout. I can also meet up with friends and do homework. If SWCC was not here I would just cruse.

Jann, age 12- If I were not here I would do what I use to. I went to school's program but there I have to pick one thing to do. I cannot just relax, like here I get to do more.

Francis, age 12- Problems I see in Kalihi are fights. But at Susannah's all the workers make us follow rules. They keep us happy and stop us all from fighting. All problems are solved.

D.J., age 11- I come here because I have fun with good activities and homework time, there are pool tables, and I play basket ball. There is a basket ball team....I learned from practice to dribble more better and communicate with your team.

Delfin, age 8-I learned to not say bad words, be respectful, responsible, safe....here I get to make new friends with activities and games with prizes and food. I learn more things, read, drawl, and use computers.

Jerald, age 8- If Susannah wasn't here I would be bored and could fight.

Daniel, age 10- If Susannah's wasn't here I don't know what I would do. I liking coming to be with friends and get help from workers on my homework. I get to spend time in the gym learning sports and playing Sham Battle.

Kyle, age 11- I don't go home afterschool because most times no one is there because they have a lot jobs. But I come to the center and get help with work, and get to hang out with friends.

Daizha, age 15- Problems I see in the community are fights, and stealing. But Susannah's helps me stay out of trouble, instead you do your work, participate in activities, volunteer and help others.

CATHOLIC CHARITIES HAWAI'I

**TESTIMONY IN SUPPORT OF HB 1905 Proposed SD1: RELATING TO HUMAN SERVICES**

TO: Senator Suzanne Chun Oakland, Chair, Senator Les Ihara, Vice Chair, and Members, Committee on Human Services

FROM: Betty Lou Larson, Legislative Liaison, Catholic Charities Hawaii

**Hearing: Tuesday, March 20, 2012; 1:45 p.m.; CR 016**

Chair Chun Oakland, Vice Chair Ihara, and Members of the Committee on Human Services:

Thank you for the opportunity to testify on HB 1905 SD1, which addresses a range of concerns on human services. I am Betty Lou Larson, Legislative Liaison for housing and homelessness issues at Catholic Charities Hawaii. Catholic Charities Hawaii supports Part 1 and Part V of this bill.

RE: PART I: giving flexibility to the Department of Human Services to utilize other funds appropriate to the department for General Assistance. Catholic Charities Hawaii remains very concerned about the possibility that many persons now on General Assistance will be forced into homelessness if their General Assistance payments are further reduced. This bill would give the department the flexibility to use savings from other programs as a stopgap measure to continue benefits, if an emergency appropriation is insufficient to meet the need.

The benefit currently is hardly enough to pay rent even at subsidized housing or special housing such as clean and sober homes. The benefit has already been reduced in FY 2012 from $353 down to $319 currently. Without help from the legislature, the benefit will be further reduced to $275 in April 2012. This reduction could force many recipients into homelessness. It would be much more costly to the State to have to provide homeless services to help these people regain housing, versus keeping them in housing with the General Assistance payments.

RE: PART V: establishes the Hawaii Interagency Council on Homelessness in statute. Catholic Charities Hawaii also supports this important measure to coordinate planning and initiatives to end homelessness in our State. Having the right government and community leaders at the table to tackle this complex issue is essential. The Council has already begun its work and has involved a multitude of stakeholders. There is no quick fix to ending homelessness. It requires ongoing effort and collaboration which the Interagency Council on Homelessness would provide. We urge your support for this ongoing initiative to end homelessness.

HAWAII SUBSTANCE ABUSE COALITION

**SB 1905 RELATING TO PUBLIC SAFETY** - DHS to draw from other funds to meet General Assistance benefits payments and maintain funding levels for public welfare.

- SENATE COMMITTEE ON HUMAN SERVICES: Senator Chun-Oakland, Chair; Senator Les Ihara, Vice Chair
- March 20, 2012 1:45 p.m.
- Conference Room 016

# HSAC Strongly Supports SB1905 HD2:

*Good Morning Chair Chun-Oakland; Vice Chair Ihara; And Distinguished Committee Members. My name is Alan Johnson, Chair of the Hawaii Substance Abuse Coalition, a hui of about 20 treatment and prevention agencies across the State.*

**Over 8,000 people enter treatment every year** in Hawai'i and over 70% complete treatment. Most of them enter clean and sober homes, relying on general assistance to pay rent.

Those **thousands of people every year who complete treatment need welfare** to begin a new life in recovery. Very soon they will find employment, reunite with their families and become productive tax paying members of society. Their term of needing general assistance is relatively brief. However, without this help, they will have a financial difficulty, which puts stress on them for maintaining their recovery. Without this help, their risk for relapse is much, much greater.

**People with addictions are a huge expense to our state budget every year.** Millions are paid for law enforcement, emergent care at hospitals, Judiciary, prisons, probation and parole. The community doesn't realize how much is lost annually due to property crime. The costs are exorbitant.

**The state's investment in treatment saves dollars** in the state budget by reducing those huge costs for crime. The investment in welfare for recovering addicts ensures continued recovery and minimizes relapse.

**Eventually recipients in recovery will end their need for financial help,** which means that general assistance for "recovering" people is a great investment for the State. It saves money in the same year it is given as well as many times over in future years due to their gainful employment, which occurs during recovery.

We appreciate the opportunity to testify and are available for questions.

IMUALLIANCE

*46-063 Emepela Pl. #U101 Kaneohe, HI 96744 · (808) 679-7454 · Kris Coffield · Co-founder/Legislative Director*

**TESTIMONY FOR HOUSE BILL 1905, HOUSE DRAFT 2, RELATING TO HUMAN SERVICES**

**Senate Committee on Human Services**
**Hon. Suzanne Chun Oakland, Chair**
**Hon. Les Ihara, Jr., Vice Chair**

**Tuesday, March 20, 2012, 1:45 PM**
**State Capitol, Conference Room 016**

Honorable Chair Chun Oakland and committee members:

I am Kris Coffield, representing the IMUAlliance, a nonpartisan political advocacy organization that currently boasts over 150 local members. On behalf of our members, we offer this testimony in support of for HB 1905, HD2, relating to human services.

Primarily an appropriations and omnibus programs bill for the Department of Human Services, we are particularly supportive of Part VI and VII of this measure. The former of these two sections encourages DHS to make available on its website information about the National Human Trafficking Resource Center hotline number, operated by the Polaris Project. It is worth noting that the hotline received 67 calls related to Hawaii, in 2011, quadruple the number that the hotline averaged between 2007-2010. The latter of these two sections establishes a task force charged with devising a comprehensive services plan for survivors of human trafficking, something that is sorely lacking at present. Currently, services are scattered between various state agencies, including the Office of Community Services, Office of the Attorney General, county prosecutors' offices, and various nonprofits. Because there is no central state plan or governing agency, the provision of services can be particularly difficult, often due to limited communications between the different agencies involved in a case.

Mahalo for the opportunity to testify in support of this bill.

Sincerely,
Kris Coffield
*Legislative Director*
IMUAlliance

TESTIMONY on HB 1905 HD 2
Relating to Human Services

Presented to the Senate Committee on Human Service
Senator Suzanne Chun-Oakland, Chair
Senator Les Ihara, Jr., Vice Chair
Tuesday, March 20, 2012

By McKay Schwenke
Adult Friends for Youth
Vice President

Chair Chun-Oakland and Members of the Senate Human Services Committee,

Adult Friends for Youth testifies in support of HB 1905, HD 2 and the proposed amendments in SD 1. The proposed SD 1 provides funding to Adult Friends for Youth for youth gang prevention and intervention services. There is a critical need for these services.

Adult Friends for Youth currently works with 26 groups and 400 high-risk youth/gang members from low income families weekly to redirect their destructive behavior to constructive behavior. This not only helps the youth, providing them the opportunity to move from the generational binds of poverty in which they were raised, but also creates a safer environment in their neighborhoods and schools, and prevents a costly law enforcement and criminal justice response from being needed later in their lives.

Another key service provided by Adult Friends for Youth is that it is able to mediate effectively between rival gangs when a conflict breaks out. When such a conflict breaks out on a high school campus or public housing, the potential for injuries is great. Adult Friends for Youth has been able to calm such situations, restoring peace to the school and community. Without continued Legislative support such interventions would not be possible.

Thank you.

The Children's Alliance
OF HAWAII, INC.

March 19, 2012

TO: Senator Suzanne Chun-Oakland, Chair
Senator Les Ihara, Jr., Vice Chair
Members of the Senate Committee on Human Services

FROM: Joan Naguwa, President
The Children's Alliance of Hawaii, Inc.

SUBJ: **Testimony in Support of HB 1905, H.D.2, S.D. 1, Relating to Human Services**
Hearing Date: Tuesday, March 20, 2012
Time: 1:45 pm
Place: Conference Room 016

Dear Chair Chun-Oakland, Vice Chair Ihara and Members of the Senate Committee on Human Services,

My name is Joan Naguwa, President/Executive Director of The Children's Alliance of Hawaii, Inc. We are in strong **support of HB 1905, HD2, S.D. 1**, Relating to Human Services.

The mission of The Children's Alliance of Hawaii, Inc. (CAH) is to provide care and support for sexually abused children, offering hope for the future. CAH serves nearly 600 children and youth and their families each year. CAH is an integral part of the statewide system of services for sexually abused children and youth. Our programs include: 1) Enhancements – providing needed goods and services for child victims, child witnesses and their siblings, residing in foster care or at home on Oahu and Kauai that enhance their ability to regain a sense of normalcy and increase self-esteem; 2) HEART (Healing Emotions with Art and Recreation Together) – an ongoing experiential program for sexually abused children and adolescents to increase their self esteem and decrease feelings of isolation;3) Ho'omaka – enabling child victims to strengthen their resiliency by working with adult mentors and developing skills in goal-setting, problem-solving, healthy relationship-building, and independent living; and 4) Strengthening Parents – parent and caregiver support groups to manage their own emotions about sexual abuse to their children and increasing their parenting skills. Our programs are not a substitute for primary therapy, but rather, are unique long term, wrap around services in support if their individual and/or traditional group therapy. Based on evidence-based best practices, CAH provides the long term support services needed to help these children to effectively manage their trauma while also dealing with normal child and adolescent developmental stages, and to achieve a successful transition into adulthood.

The need for access to CAH services for sexually abused children is significant as over 300 reported cases are handled by the Dept. of Human Services each year. To add to this figure, national statistics demonstrate that there are hundreds more cases of child sexual abuse that are unreported. If left untreated, victims of child sexual abuse often experience serious social problems, such as substance abuse, unemployment, homelessness, poor academic

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achievement, and criminal behaviors. For example, experts agree that sexually abused children are four (4) times more likely than non-sexually abused youth to have delinquent or criminal behaviors leading to incarceration.

The appropriation of $150,000 for CAH's services included in HB 1905, HD2, S.D. 1, is critically needed to continue to meet the long term needs of these vulnerable children and assist them to become productive citizens of Hawaii. We fully recognize Hawaii's very difficult economic situation and the serious challenges faced by the Hawaii State Legislature. However, without this appropriation, CAH will significantly reduce or eliminate its programs and services, creating a strong likelihood for these children to engage in harmful behaviors at a greater cost to the State of Hawaii.

We strongly urge for your support of HB 1905, HD2, S.D.1, Relating to Human Services.

Thank you for the opportunity to testify.

PACIFIC ALLIANCE to STOP SLAVERY

DATE: February 13, 2012

ATTN: SENATE COMMITTEE ON HUMAN SERVICES

Senator Suzanne Chun Oakland, Chair
Senator Les Ihara, Jr., Vice Chair
Senator Josh Green
Senator Sam Slom

RE: TESTIMONY IN STRONG SUPPORT OF **HB1905** – RELATING TO HUMAN SERVICES

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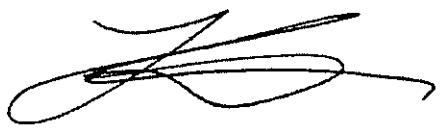
Dear Committee on Human Services:

The Pacific Alliance to Stop Slavery (PASS) is in strong support of HB1905. PASS serves victims of Human Trafficking for sex or labor in the state of Hawaii and has a support base of over 7000 persons. We are in communion with Imua Alliance and Polaris Project with regard to this important bill and defer to Polari Projects with their recommendations for amendments to SB2123.

PASS is one of Hawaii's few services that helps to heal survivors of human trafficking. We testify that there are no specific services tailored to the survivors of this crime. As a result, survivors fall through the cracks or are often re-victimized and criminalized as either "prostitutes" if they are sex trafficked victims or "illegal immigrants" if they are labor trafficked victims. Hawaii must accurately and effectively address the handling of human trafficking survivors.

We urge you to pass this measure.

Sincerely,



Kathryn Xian
Executive Director
Pacific Alliance to Stop Slavery

**TESTIMONY ON HB 1905, SD 1 RELATING TO CHILD WELFARE**
**BEFORE THE SENATE COMMITTEE ON HUMAN SERVICES**

March 20, 2012 1:45 pm Conference Rm. 016

Aloha Chair Chun Oakland, Vice-Chair Ihara, and members of the Senate Committee on Human Services. My name is Stephen Morse, and I am the Executive Director of Blueprint for Change (BFC). I am here to testify in **support of HB 1905, SD 1 Relating to Child Welfare**, particularly as it relates to allowing the Department of Human Services to draw from general funds to maintain levels of service in social service programs.

Members, BFC is a non-profit, charitable organization that is the technical, financial, and administrative support entity for five Neighborhood Place programs statewide that provide support and family strengthening services to families at risk of child abuse and neglect. We are a community-based prevention program that is funded primarily by a POS contract by the Department of Human Services as part of the Differential Response System. Our Neighborhood Place programs are unique among CAN prevention programs because they are the only places where children and families at risk of child abuse and neglect can get services without a referral or appointment and by simply knocking on the door.

During the past 15 years, the Neighborhood Places and other prevention programs funded under the Differential Response System have been recognized as chiefly responsible for the turnaround in child abuse and neglect rates in Hawaii, from one of the highest in the country, to one of the lowest. For example, in 2003, there were 7,835 reports of CAN made to the State. In 2007, reports went down to 4,690. In the process of helping reduce CAN reports, these prevention programs have also saved the State billions of dollars in social costs, such as welfare payments, foster care payments, unemployment compensation, substance abuse treatment, and incarceration. As such, we are the most cost effective programs in the State system.

But, the severe downturn in our economy has had a huge negative impact on funding for our programs. Our budget, for example, has been cut by $335,000 over the past three years, a combined 42% cut from 2008. These cuts have led to reduction in force and staff hours and have made it difficult to maintain service levels. We believe the reduction in prevention services has led to increases in CAN reports. For instance, in 2008, there were 4,628 reports to the State's Child Welfare System. In 2009, reports increased to 5,939. This increase of over 1,300 reports represents the single greatest jump in annual CAN reports since these statistics began being kept in 1975.

HB 1905, SD 1 will provide the Blueprint for Change/Neighborhood Place partnership with the funding necessary to bring service levels back to where they were three years ago. Mahalo for allowing us the opportunity to testify this afternoon.

PHOCUSED

PROTECTING HAWAII'S OHANA, CHILDREN, UNDER SERVED, ELDERLY AND DISABLED



TO: Senator Suzanne Chun Oakland, Chair
Committee on Human Services

FROM: Alex Santiago, Executive Director of PHOCUSED

HEARING DATE: March 20, 2012, 1:45PM, Room 016

RE: Support for HB 1905 SD1, Allows the department of human services to draw from other funds in the event the general assistance appropriation is insufficient to meet benefits payments.

Chair Chun Oakland and members of the Committee on Human Services,

I am Alex Santiago, the Executive Director of PHOCUSED, a coalition of health, housing, human service agencies and individual advocates voicing the needs of the marginalized and underserved in Hawaii. **PHOCUSED strongly supports HB 1905 SD1**, which allows the department of human services to draw from other funds in the event the general assistance appropriation is insufficient to meet benefits payments. We all support the measures added on to HB1905 SD1; however, we will limit our written comments to the General Assistance issue.

The General Assistance Program is a wholly state funded program designed to help disabled persons who are unable to work and are ineligible for any other federal or state assistance. Currently there are 5, 584 person receiving general assistance. Over the years, this program has seen the number of eligible people *decrease* as the DHS has been able to move some of these people onto social security and other disability support programs. However, often persons with disabilities who have been recently injured or newly diagnosed with a life threatening illness cannot become eligible for other programs until their disability is defined as long term and thus they are eligible for NO cash assistance other than G.A.

Since the legislature puts this appropriation into a block grant, as the numbers of newly eligible needy person grows, the amount of money each person can receive shrinks. In October 2011, the small amount of assistance which was $344 was reduced to $319 a month. If a new appropriation is not provided, DHS will have to reduce this amount further to $275 a month beginning April 2012. This monthly amount is used primarily for shelter, so reducing this monthly allotment will certainly result in increased homelessness… and these people are persons with disabilities and have no other means of support.

We urge you to support HB1905SD1.

Thank you for this opportunity to testify.

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**From:** mailinglist@capitol.hawaii.gov
**Sent:** Monday, March 19, 2012 3:42 PM
**To:** HMS Testimony
**Cc:** fajotinacare@aol.com
**Subject:** Testimony for HB1905 on 3/20/2012 1:45:00 PM

Testimony for HMS 3/20/2012 1:45:00 PM HB1905

Conference room: 016
Testifier position: Support
Testifier will be present: Yes
Submitted by: Lilia P. Fajotina ( ARCA President)
Organization: Alliancé of Residential Care Administrators
E-mail: fajotinacare@aol.com
Submitted on: 3/19/2012

Comments:
I Strongly Support the intent of the HB 1905.

**From:** mizuno1 - Michael
**Sent:** Monday, March 19, 2012 11:49 AM
**To:** HMS Testimony
**Subject:** FW: HB 1905 and 2126
**Attachments:** DMEPOSSupplierStandards.pdf; Stark411.354.pdf; Nevada Licensure Statutes and regulations.wps

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**From:** violeta arnobit [mailto:varnobithawaii@yahoo.com]
**Sent:** Monday, March 19, 2012 9:13 AM
**To:** Rep. John Mizuno; mizuno1 - Michael
**Subject:** HB 1905 and 2126

Aloha Mike,
Here is a copy of Nevadas regulation on Medical Distributor of Equipment and Gases(relating to Oxygen) that we have foster home, care homes, case managers, physicians (owns sleep lab companies and providing DME) who are conducting this business and inducing self referral to their entity which is a violation of anti Stark law.
Also the supplier standards for medical equipment supplier is attached.
It is not fair for us accredited suppliers who have a physical location to conduct business, pays for accreditation, commercial and professional liability insurance uphold CMS requirements and compliance and help prevent fraud and abuse in our industry.

**2. The board shall not issue a license to conduct an MDEG provider or MDEG wholesaler:**
**(a) To any actively practicing health professional; or**
**(b) To any partnership, corporation or association in which an actively practicing health professional has a controlling interest or in which ownership of 10 percent or more of the available stock is held by one or more actively practicing health professionals.**
Can we have this language, The Department of Health and DHS shall adopt rules by CMS(Center for Medicare and Medicaid Services) pursuant to DMEPOS supplier standards in accordance with the requirements at §424.58.
CMS requirements on supplier standards establishing standards regarding the reputable and responsible character of service providers and adopting anti Stark law.
Specifically, I am concern of case managers and caregivers having ownership and doing business to induce self referral and not in compliance on supplier standards. One of the requirements as stated. This has increase fraud and abuse for many years, over utilization on incontinence supplies, providing medical equipment which is not medically necessary but justifying need as nurse case managers doing home visits.
Another area of concern that RN case managers or RN evaluators does not have oversight for doing re certification to our CNA while we as a state certified school must be licensed and have to undergo every two years of site inspection and our RN evaluators must submit on curriculum review and observation of competency during our CNA classes. This was raised by the CTA staff and I did inform Lori Tsuruda on this concern as well. They were not agreeable on the

initial proposal of this RN evaluators until administrative rules were change. We make class schedule flexible for them and a very reasonable rate in fact our community service charging only $100, for we believe in quality training , but still they go for someone who they think provide patients for them, again another self referral case.
There is so much inconsistency of our RACCP and CNA which impact quality of care, frequent re admissions, over utilization, fraud and abuse, in the long run eroding financial capability on DOH and DHS. Please lets all help make our program cost effective, upholding professional and ethical standards for a sustainable health care program in our community.
Please feel free to call me at 306 3766 and let me know if we can still get this on SB 2126.
Thank you,

Violeta A. Arnobit, BSN,RN
**CEO**
**Ace Medical Inc.**
**Comprehensive Health Care Systems**
**Main Office:**
94-910 Moloalo St
Waipahu,HI 96797
**Tel. No.808 678-3600 ext. 208**
**Fax No.808 678-3604**
**Cell No. 808 306-3766**

**Special payment rules for items furnished by DMEPOS suppliers and issuance of DMEPOS supplier billing privileges.**

Supplier Standards

(a) *Definitions.* As used in this section, the following definitions apply:

*Accredited DMEPOS suppliers* means suppliers that have been accredited by a recognized independent accreditation organization approved by CMS in accordance with the requirements at §424.58.

*Affiliate* means a person or organization that is related to another person or organization through a compensation arrangement or ownership.

*Assessment* means a sum certain that CMS or the Office of Inspector General (OIG) may assess against a DMEPOS supplier under Titles XI, XVIII, or XXI of the Social Security Act or as specified in this chapter.

*Attended facility-based polysomnogram* means a comprehensive diagnostic sleep test including at least electroencephalography, electro-oculography, electromyography, heart rate or electrocardiography, airflow, breathing effort, and arterial oxygen saturation furnished in a sleep laboratory facility in which a technologist supervises the recording during sleep time and has the ability to intervene if needed.

*Authorized surety* means a surety that has been issued a Certificate of Authority by the U.S. Department of the Treasury as an acceptable surety on Federal bonds and the certificate has neither expired nor been revoked.

*Civil money penalty (CMP)* means a sum that CMS has the authority, as implemented by 42 CFR 402.1(c); or OIG has the authority, under section 1128A of the Act or 42 CFR part 1003, to impose on a supplier as a penalty.

*CMS approved accreditation organization* means a recognized independent accreditation organization approved by CMS under §424.58.

*Continuous positive airway pressure (CPAP) device* means a machine that introduces air into the breathing passages at pressures high enough to overcome obstructions in the airway in order to improve airflow. The airway pressure delivered into the upper airway is continuous during both inspiration and expiration.

*Direct solicitation* means direct contact, which includes, but is not limited to, telephone, computer, e-mail, instant messaging or in-person contact, by a DMEPOS supplier or its agents to a Medicare beneficiary without his or her consent for the purpose of marketing the DMEPOS supplier's health care products or services or both.

*DMEPOS* stands for durable medical equipment, prosthetics, orthotics and supplies.

*DMEPOS supplier* means an entity or individual, including a physician or a Part A provider, which sells or rents Part B covered items to Medicare beneficiaries and which meets the standards in paragraphs (c) and (d) of this section.

*Final adverse action* means one or more of the following actions:

(i) A Medicare-imposed revocation of any Medicare billing privileges.

(ii) Suspension or revocation of a license to provide health care by any State licensing authority.

(iii) Revocation for failure to meet DMEPOS quality standards.

(iv) A conviction of a Federal or State felony offense (as defined in §424.535(a)(3)(i) within the last 10 years preceding enrollment, revalidation, or re-enrollment.

(v) An exclusion or debarment from participation in a Federal or State health care program.

*Government-operated supplier* is a DMEPOS supplier owned or operated by a Federal, State, or Tribal entity.

*Independent accreditation organization* means an accreditation organization that accredits a supplier of DMEPOS and other items and services for a specific DMEPOS product category or a full line of DMEPOS product categories.

*Medicare covered items* means medical equipment and supplies as defined in section 1834(j)(5) of the Act.

*National Supplier Clearinghouse (NSC)* is the contractor that is responsible for the enrollment and re-enrollment process for DMEPOS suppliers.

*Penal sum* is the maximum obligation of the surety if a loss occurs.

*Rider* means a notice issued by a surety that a change in the bond has occurred or will occur.

*Sleep test* means an attended or unattended diagnostic test for a sleep disorder whether performed in or out of a sleep laboratory. The 'provider of the sleep test' is the individual or entity that directly or indirectly administers and/or interprets the sleep test and/or furnishes the sleep test device used to administer the sleep test.

*Sufficient evidence* means documents CMS may supply to the surety in order to establish that a DMEPOS supplier had received Medicare funds in excess of the amount due and payable under the statute and regulations, the amount of a CMP, or the amount of some other assessment against the DMEPOS supplier.

*Surety bond* means a bond issued by one or more sureties under 31 U.S.C. 9304 through 9308 and 31 CFR parts 223, 224, and 225.

*Unpaid claim* means an overpayment made by the Medicare program to the DMEPOS supplier for which the DMEPOS supplier is responsible, plus accrued interest that is effective 90 days after the date of the notice sent to the DMEPOS supplier of the overpayment. If a written agreement for payment, acceptable to CMS, is made, an *unpaid claim* also means a Medicare overpayment for which the DMEPOS supplier is responsible, plus accrued interest after the DME supplier's default on the arrangement.

(b) *General rule.* A DMEPOS supplier must meet the following conditions in order to be eligible to receive payment for a Medicare-covered item:

(1) The supplier has submitted a completed application to CMS to furnish Medicare-covered items including required enrollment forms. (The supplier must enroll separate physical locations it uses to furnish Medicare-covered DMEPOS, with the exception of locations that it uses solely as warehouses or repair facilities.)

(2) The item was furnished on or after the date CMS issued to the supplier a DMEPOS supplier number conveying billing privileges. (CMS issues only one supplier number for each location.) This requirement does not apply to items furnished incident to a physician's service.

(3) CMS has not revoked or excluded the DMEPOS supplier's privileges during the period which the item was furnished has not been revoked or excluded.

(4) A supplier that furnishes a drug used as a Medicare-covered supply with durable medical equipment or prosthetic devices must be licensed by the State to dispense drugs (A supplier of drugs must bill and receive payment for the drug in its own name. A physician, who is enrolled as a DMEPOS supplier, may dispense, and bill for, drugs under this standard if authorized by the State as part of the physician's license.)

(5) The supplier has furnished to CMS all information or documentation required to process the claim.

(c) *Application certification standards.* The supplier must meet and must certify in its application for billing privileges that it meets and will continue to meet the following standards:

(1) Operates its business and furnishes Medicare-covered items in compliance with the following applicable laws:

(i) Federal regulatory requirements that specify requirements for the provision of DMEPOS and ensure accessibility for the disabled.

(ii) State licensure and regulatory requirements. If a State requires licensure to furnish certain items or services, a DMEPOS supplier—

(A) Must be licensed to provide the item or service;

(B) Must employ the licensed professional on a full-time or part-time basis, except for DMEPOS suppliers who are—

( *1* ) Awarded competitive bid contracts using subcontractors to meet this standard; or

( *2* ) Allowed by the State to contract licensed services as described in paragraph (c)(1)(ii)(C) of this section.

(C) Must not contract with an individual or other entity to provide the licensed services, unless allowed by the State where the licensed services are being performed; and

(iii) Local zoning requirements.

(2) Has not made, or caused to be made, any false statement or misrepresentation of a material fact on its application for billing privileges. (The supplier must provide complete and accurate information in response to questions on its application for billing privileges. The supplier must report to CMS any changes in information supplied on the application within 30 days of the change.);

(3) Must have the application for billing privileges signed by an individual whose signature binds a supplier;

(4) Fills orders, frabicates, or fits items from its own inventory or by contracting with other companies for the purchase of items necessary to fill the order. If it does, it must provide, upon request, copies of contracts or other documentation showing compliance with this standard. A supplier may not contract with any entity that is currently excluded from the Medicare program, any State health care programs, or from any other Federal Government Executive Branch procurement or nonprocurement program or activity;

(5) Advises beneficiaries that they may either rent or purchase inexpensive or routinely purchased durable medical equipment, and of the purchase option for capped rental durable medical equipment, as defined in §414.220(a) of this subchapter. (The supplier must provide, upon request, documentation that it has provided beneficiaries with this information, in the form of copies of letters, logs, or signed notices.);

(6) Honors all warranties expressed and implied under applicable State law. A supplier must not charge the beneficiary or the Medicare program for the repair or replacement of Medicare covered items or for services covered under warranty. This standard applies to all purchased and rented items, including capped rental items, as described in §414.229 of this subchapter. The supplier must provide, upon request, documentation that it has provided beneficiaries with information about Medicare covered items covered under warranty, in the form of copies of letters, logs, or signed notices;

(7) Maintains a physical facility on an appropriate site. An appropriate site must meet all of the following:

(i) Must meet the following criteria:

(A) Except for State-licensed orthotic and prosthetic personnel providing custom fabricated orthotics or prosthetics in private practice, maintains a practice location that is at least 200 square feet beginning—

( *1* ) September 27, 2010 for a prospective DMEPOS supplier;

( *2* ) The first day after termination of an expiring lease for an existing DMEPOS supplier with a lease that expires on or after September 27, 2010 and before September 27, 2013; or

( *3* ) September 27, 2013, for an existing DMEPOS supplier with a lease that expires on or after September 27, 2013.

(B) Is in a location that is accessible to the public, Medicare beneficiaries, CMS, NSC, and its agents. (The location must not be in a gated community or other area where access is restricted.)

(C) Is accessible and staffed during posted hours of operation.

(D) Maintains a permanent visible sign in plain view and posts hours of operation. If the supplier's place of business is located within a building complex, the sign must be visible at the main entrance of the building or the hours can be posted at the entrance of the supplier.

(E) Except for business records that are stored in centralized location as described in paragraph (c)(7)(ii) of this section, is in a location that contains space for storing business records (including the supplier's delivery, maintenance, and beneficiary communication records).

(F) Is in a location that contains space for retaining the necessary ordering and referring documentation specified in §424.516(f).

(ii) May be the centralized location for all of the business records and the ordering and referring documentation of a multisite supplier.

(iii) May be a "closed door" business, such as a pharmacy or supplier providing services only to beneficiaries residing in a nursing home, that complies with all applicable Federal, State, and local laws and regulations. "Closed door" businesses must comply with all the requirements in this paragraph.

(8) Permits CMS, the NSC, or agents of CMS or the NSC to conduct on-site inspections to ascertain supplier compliance with the requirements of this section.

(9) Maintains a primary business telephone that is operating at the appropriate site listed under the name of the business locally or toll-free for beneficiaries.

(i) Cellular phones, beepers, or pagers must not be used as the primary business telephone.

(ii) Calls must not be exclusively forwarded from the primary business telephone listed under the name of the business to a cellular phone, beeper, or pager.

(iii) Answering machines, answering services, facsimile machines or combination of these options must not be used exclusively as the primary business telephone during posted operating hours.

(10) Has a comprehensive liability insurance policy in the amount of at least $300,000 that covers both the supplier's place of business and all customers and employees of the supplier. In the case of a supplier that manufactures its own items, this insurance must also cover product liability and completed operations. Failure to maintain required insurance at all times will result in revocation of the supplier's billing privileges retroactive to the date the insurance lapsed;

(11) Agree not to make a direct solicitation (as defined in §424.57(a)) of a Medicare beneficiary unless one or more of the following applies:

(i) The individual has given written permission to the supplier or the ordering physician or non-physician practitioner to contact them concerning the furnishing of a Medicare-covered item that is to be rented or purchased.

(ii) The supplier has furnished a Medicare-covered item to the individual and the supplier is contacting the individual to coordinate the delivery of the item.

(iii) If the contact concerns the furnishing of a Medicare-covered item other than a covered item already furnished to the individual, the supplier has furnished at least one covered item to the individual during the 15-month period preceding the date on which the supplier makes such contact.

(12) Must be responsible for the delivery of Medicare covered items to beneficiaries and maintain proof of delivery. (The supplier must document that it or another qualified party has at an appropriate time, provided beneficiaries with necessary information and instructions on how to use Medicare-covered items safely and effectively);

(13) Must answer questions and respond to complaints a beneficiary has about the Medicare-covered item that was sold or rented. A supplier must refer beneficiaries with Medicare questions to the appropriate carrier. A supplier must maintain documentation of contacts with beneficiaries regarding complaints or questions;

(14) Must maintain and replace at no charge or repair directly, or through a service contract with another company, Medicare-covered items it has rented to beneficiaries. The item must function as required and intended after being repaired or replaced;

(15) Must accept returns from beneficiaries of substandard (less than full quality for the particular item or unsuitable items, inappropriate for the beneficiary at the time it was fitted and rented or sold);

(16) Must disclose these supplier standards to each beneficiary to whom it supplies a Medicare-covered item;

(17) Must comply with the disclosure provisions in §420.206 of this subchapter;

(18) Must not convey or reassign a supplier number;

(19) Must have a complaint resolution protocol to address beneficiary complaints that relate to supplier standards in paragraph (c) of this section and keep written complaints, related correspondence and any notes of actions taken in response to written and oral complaints. Failure to maintain such information may be considered evidence that supplier standards have not been met. (This information must be kept at its physical facility and made available to CMS, upon request.);

(20) Must maintain the following information on all written and oral beneficiary complaints, including telephone complaints, it receives:

(i) The name, address, telephone number, and health insurance claim number of the beneficiary.

(ii) A summary of the complaint; the date it was received; the name of the person receiving the complaint, and a summary of actions taken to resolve the complaint.

(iii) If an investigation was not conducted, the name of the person making the decision and the reason for the decision.

(21) Provides to CMS, upon request, any information required by the Medicare statute and implementing regulations.

(22) All suppliers of DMEPOS and other items and services must be accredited by a CMS-approved accreditation organization in order to receive and retain a supplier billing number. The accreditation must indicate the specific products and services, for which the supplier is accredited in order for the supplier to receive payment for those specific products and services.

(23) All DMEPOS suppliers must notify their accreditation organization when a new DMEPOS location is opened. The accreditation organization may accredit the new supplier location for three months after it is operational without requiring a new site visit.

(24) All DMEPOS supplier locations, whether owned or subcontracted, must meet the DMEPOS quality standards and be separately accredited in order to bill Medicare. An accredited supplier may be denied enrollment or their enrollment may be revoked, if CMS determines that they are not in compliance with the DMEPOS quality standards.

(25) All DMEPOS suppliers must disclose upon enrollment all products and services, including the addition of new product lines for which they are seeking accreditation. If a new product line is added after enrollment, the DMEPOS supplier will be responsible for notifying the accrediting

body of the new product so that the DMEPOS supplier can be re-surveyed and accredited for these new products.

(26) Must meet the surety bond requirements specified in paragraph (d) of this section.

(27) Must obtain oxygen from a State-licensed oxygen supplier (applicable only to those suppliers in States that require oxygen licensure.)

(28) Is required to maintain ordering and referring documentation consistent with the provisions found in §424.516(f)

(29)(i) Except as specified in paragraph (c)(29)(ii) of this section, is prohibited from sharing a practice location with any other Medicare supplier or provider.

(ii) The prohibition specified in paragraph (c)(29)(i) of this section is not applicable at a practice location that meets one of the following:

(A) Where a physician whose services are defined in section 1848(j)(3) of the Act or a nonphysician practitioner, as described in section 1842(b)(18)(C) of the Act, furnishes items to his or her own patient as part of his or her professional service.

(B) Where a physical or occupational therapist whose services are defined in sections 1861(p) and 1861(g) of the Act, furnishes items to his or her own patient as part of his or her professional service.

(C) Where a DMEPOS supplier is co-located with and owned by an enrolled Medicare provider (as described in §489.2(b) of this chapter). The DMEPOS supplier—

*(1)* Must operate as a separate unit; and

*(2)* Meet all other DMEPOS supplier standards.

(30)(i) Except as specified in paragraph (c)(30)(ii) of this section, is open to the public a minimum of 30 hours per week.

(ii) The provision of paragraph (c)(30)(i) of this section is not applicable at a practice location where a—

(A) Physician whose services are defined in section 1848(j)(3) of the Act furnishes items to his or her own patient(s) as part of his or her professional service;

(B) Licensed non-physician practitioners whose services are defined in sections 1861(p) and 1861(g) of the Act furnishes items to his or her own patient(s) as part of his or her professional service; or

(C) DMEPOS supplier is working with custom made orthotics and prosthetics.

(d) *Failure to meet standards.* CMS will revoke a supplier's billing privileges if it is found not to meet the standards in paragraphs (b) and (c) of this section. (The revocation is effective 15 days after the entity is sent notice of the revocation, as specified in §405.874 of this subchapter.)

(e) *Failure to meet standards* —(1) *Revocation.* CMS revokes a supplier's billing privileges if it is found not to meet the standards in paragraphs (b) and (c) of this section. Except as otherwise provided in this section, the revocation is effective 30 days after the entity is sent notice of the revocation, as specified in §405.874 of this subchapter.

(2) *Overpayments associated with final adverse actions.* CMS or a CMS contractor may reopen (in accordance with §405.980 of this chapter) all Medicare claims paid on or after the date of a final adverse action (as defined in paragraph (a) of this section) in order to establish an overpayment determination.

(f) *Payment prohibition.* No Medicare payment will be made to the supplier of a CPAP device if that supplier, or its affiliate, is directly or indirectly the provider of the sleep test used to diagnose the beneficiary with obstructive sleep apnea. This prohibition does not apply if the sleep test is an attended facility-based polysomnogram.

[65 FR 60377, Oct. 11, 2000, as amended at 71 FR 48409, Aug. 18, 2006; 73 FR 69939, Nov. 19, 2008; 75 FR 52648, Aug. 27, 2010]

**Editorial Note:** At 74 FR 198, Jan. 2, 2009, §424.57 was amended by redesignating paragraphs (d) and (e) as paragraphs (e) and (f), adding a new paragraph (d) and in newly redesignated paragraph (e), by removing the cross-reference, "paragraphs (b) and (c)" and adding the cross-reference "paragraphs (b), (c), and (d)" however, these amendments could not be incorporated due to inaccurate amendatory instruction. For the convenience of the user, the added text is set forth as follows:

**§ 424.57 Special payment rules for items furnished by DMEPOS suppliers and issuance of DMEPOS supplier billing privileges.**

(d) *Surety bonds requirements* —(1) *Effective date of surety bond requirements* . (i) *DMEPOS suppliers seeking enrollment or with a change in ownership* . Except as provided in paragraph (d)(15) of this section, beginning May 4, 2009, DMEPOS suppliers seeking to enroll or to change the ownership of a supplier of DMEPOS must meet the requirements of paragraph (d) of this section for each assigned NPI for which the DMEPOS supplier is seeking to obtain Medicare billing privileges.

(ii) *Existing DMEPOS suppliers* . Except as provided in paragraph (d)(15) of this section, beginning October 2, 2009, each Medicare-enrolled DMEPOS supplier must meet the requirements of paragraph (d) of this section for each assigned NPI to which Medicare has granted billing privileges.

(2) *Minimum requirements for a DMEPOS supplier* . (i) A supplier enrolling in the Medicare program, making a change in ownership, or responding to a revalidation or reenrollment request

must submit to the NSC a surety bond from an authorized surety of $50,000 and if required by the NSC an elevated bond amount as described in paragraph (d)(3) of this section with its paper or electronic Medicare enrollment application (CMS–855S, OMB number 0938–0685). The term of the initial surety bond must be effective on the date that the application is submitted to the NSC.

(ii) A supplier that seeks to become an enrolled DMEPOS supplier through a purchase or transfer of assets or ownership interest must submit to the NSC a surety bond from an authorized surety of $50,000 and if required by the NSC an elevated bond amount as described in paragraph (d)(3) of this section that is effective from the date of the purchase or transfer in order to exercise billing privileges as of that date. If the bond is effective at a later date, the effective date of the new DMEPOS supplier billing privileges is the effective date of the surety bond as validated by the NSC.

(iii) A DMEPOS supplier enrolling a new practice location must submit to the NSC a new surety bond from an authorized surety or an amendment or rider to the existing bond, showing that the new practice location is covered by an additional base surety bond of $50,000 or, as necessary, an elevated surety bond amount as described in paragraph (d)(3) of this section.

(3) *Elevated surety bond amounts* . (i) If required, a DMEPOS supplier must obtain and maintain a base surety bond in the amount of $50,000 as specified in paragraph (d)(2) of this section and an elevated surety bond in the amount prescribed by the NSC as described in paragraph (d)(3)(ii) of this section.

(ii) The NSC prescribes an elevated surety bond amount of $50,000 per occurrence of an adverse legal action within the 10 years preceding enrollment, revalidation, or reenrollment, as defined in paragraph (a) of this section.

(4) *Type and terms of the surety bond* . (i) *Type of bond* . A DMEPOS supplier must submit a bond that is continuous.

(ii) *Minimum requirements of liability coverage* . (A) The terms of the bond submitted by a DMEPOS supplier for the purpose of complying with this section must meet the minimum requirements of liability coverage ($50,000) and surety and DMEPOS supplier responsibility as set forth in this section.

(B) CMS requires a supplier to submit a bond that on its face reflects the requirements of this section. CMS revokes or denies a DMEPOS supplier's billing privileges based upon the submission of a bond that does not reflect the requirements of paragraph (d) of this section.

(5) *Specific surety bond requirements* . (i) The bond must guarantee that the surety will, within 30 days of receiving written notice from CMS containing sufficient evidence to establish the surety's liability under the bond of unpaid claims, CMPs, or assessments, pay CMS a total of up to the full penal amount of the bond in the following amounts:

(A) The amount of any unpaid claim, plus accrued interest, for which the DMEPOS supplier is responsible.

(B) The amount of any unpaid claims, CMPs, or assessments imposed by CMS or OIG on the DMEPOS supplier, plus accrued interest.

(ii) The bond must provide the following: The surety is liable for unpaid claims, CMPs, or assessments that occur during the term of the bond.

(iii) If the DMEPOS supplier fails to furnish a bond meeting the requirements of paragraph (d) of this section, fails to submit a rider when required, or if the DMEPOS supplier's billing privileges are revoked, the last bond or rider submitted by the DMEPOS supplier remains in effect until the last day of the surety bond coverage period and the surety remains liable for unpaid claims, CMPs, or assessments that—

(A) CMS or the OIG imposes or asserts against the DMEPOS supplier based on overpayments or other events that took place during the term of the bond or rider; and

(B) Were imposed or assessed by CMS or the OIG during the 2 years following the date that the DMEPOS supplier failed to submit a bond or required rider, or the date the DMEPOS supplier's billing privileges were terminated, whichever is later.

(6) *Cancellation of a bond and lapse of surety bond coverage* . (i) A DMEPOS supplier may cancel its surety bond and must provide written notice at least 30 days before the effective date of the cancellation to the NSC and the surety.

(ii) Cancellation of a surety bond is grounds for revocation of the DMEPOS supplier's Medicare billing privileges unless the DMEPOS supplier provides a new bond before the effective date of the cancellation. The liability of the surety continues through the termination effective date.

(iii) If CMS receives notification of a lapse in bond coverage from the surety, the DMEPOS supplier's billing privileges are revoked. During this lapse, Medicare does not pay for items or services furnished during the gap in coverage, and the DMEPOS supplier is held liable for the items or services (that is, the DMEPOS supplier would not be permitted to charge the beneficiary for the items or services).

(iv) The surety must immediately notify the NSC if there is a lapse in the surety's coverage of the DMEPOS supplier's coverage.

(7) *Actions under the surety bond* . The bond must provide that actions under the bond may be brought by CMS or by CMS contractors.

(8) *Required surety information on the surety bond* . The bond must provide the surety's name, street address or post office box number, city, state, and zip code.

(9) *Change of surety* . A DMEPOS supplier that obtains a replacement surety bond from a different surety to cover the remaining term of a previously obtained bond must submit the new surety bond to the NSC at least 30 days prior to the expiration of the previous surety bond. There must be no gap in the coverage of the surety bond periods. If a gap in coverage exists, the NSC revokes the supplier's billing privileges and does not pay for any items or services furnished by the DMEPOS supplier during the period for which no bond coverage was available. If a DMEPOS supplier changes its surety during the term of the bond, the new surety is responsible for any overpayments, CMPs, or assessments incurred by the DMEPOS supplier beginning with the effective date of the new surety bond. The previous surety is responsible for any overpayments, CMPs, or assessments that occurred up to the date of the change of surety.

(10) *Parties to the surety bond* . The surety bond must name the DMEPOS supplier as Principal, CMS as Obligee, and the surety (and its heirs, executors, administrators, successors and assignees, jointly and severally) as surety.

(11) *Effect of DMEPOS supplier's failure to obtain, maintain, and timely file a surety bond* . (i) CMS revokes the DMEPOS supplier's billing privileges if an enrolled supplier fails to obtain, file timely, or maintain a surety bond as specified in this subpart and CMS instructions. Notwithstanding paragraph (e) of this section, the revocation is effective the date the bond lapsed and any payments for items furnished on or after that date must be repaid to CMS by the DMEPOS supplier.

(ii) CMS denies billing privileges to a supplier if the supplier seeking to become an enrolled DMEPOS supplier fails to obtain and file timely a surety bond as specified with this subpart and CMS instructions.

(12) *Evidence of DMEPOS supplier's compliance.* CMS may at any time require a DMEPOS supplier to show compliance with the requirements of paragraph (d) of this section.

(13) *Effect of subsequent DMEPOS supplier payment.* If a surety has paid an amount to CMS on the basis of liability incurred under a bond and CMS subsequently collects from the DMEPOS supplier, in whole or in part, on the unpaid claim, CMPs, or assessment that was the basis for the surety's liability, CMS reimburses the surety the amount that it collected from the DMEPOS supplier, up to the amount paid by the surety to CMS, provided the surety has no other liability to CMS under the bond.

(14) *Effect of review reversing determination* . If a surety has paid CMS on the basis of liability incurred under a surety bond and to the extent the DMEPOS supplier that obtained the bond is subsequently successful in appealing the determination that was the basis of the unpaid claim, CMP, or assessment that caused the DMEPOS supplier to pay CMS under the bond, CMS refunds the DMEPOS supplier the amount the DMEPOS supplier paid to CMS to the extent that the amount relates to the matter that was successfully appealed, provided all review, including judicial review, has been completed on the matter.

(15) *Exception to the surety bond requirement* —(i) *Qualifying entities and requirements.* (A) Government-operated DMEPOS suppliers are provided an exception to the surety bond

requirement if the DME supplier has provided CMS with a comparable surety bond under State law.

(B) State-licensed orthotic and prosthetic personnel in private practice making custom made orthotics and prosthetics are provided an exception to the surety bond requirement if—

( *1* ) The business is solely-owned and operated by the orthotic and prosthetic personnel, and

( *2* ) The business is only billing for orthotic, prosthetics, and supplies.

(C) Physicians and nonphysician practitioners as defined in section 1842(b)(18) of the Act are provided an exception to the surety bond requirement when items are furnished only to the physician or nonphysician practitioner's own patients as part of his or her physician service.

(D) Physical and occupational therapists in private practice are provided an exception to the surety bond requirement if—

( *1* ) The business is solely-owned and operated by the physical or occupational therapist;

( *2* ) The items are furnished only to the physical or occupational therapist's own patients as part of his or her professional service; and

( *3* ) The business is only billing for orthotics, prosthetics, and supplies.

(ii) *Loss of a DMEPOS supplier exception.* A DMEPOS supplier that no longer qualifies for an exception as described in paragraph (d)(15)(i) of this section must submit a surety bond to the NSC in accordance with requirements of paragraph (d) of this section within 60 days after it knows or has reason to know that it no longer meets the criteria for an exception.

compensation, must be made available to the Secretary upon request.

[66 FR 956, Jan. 4, 2001]

### §411.353 Prohibition on certain referrals by physicians and limitations on billing.

(a) *Prohibition on referrals.* Except as provided in this subpart, a physician who has a direct or indirect financial relationship with an entity, or who has an immediate family member who has a direct or indirect financial relationship with the entity, may not make a referral to that entity for the furnishing of DHS for which payment otherwise may be made under Medicare. A physician's prohibited financial relationship with an entity that furnishes DHS is not imputed to his or her group practice or its members or its staff; however, a referral made by a physician's group practice, its members, or its staff may be imputed to the physician, if the physician directs the group practice, its members, or its staff to make the referral or if the physician controls referrals made by his or her group practice, its members, or its staff.

(b) *Limitations on billing.* An entity that furnishes DHS pursuant to a referral that is prohibited by paragraph (a) of this section may not present or cause to be presented a claim or bill to the Medicare program or to any individual, third party payer, or other entity for the DHS performed pursuant to the prohibited referral.

(c) *Denial of payment.* Except as provided in paragraph (e) of this section, no Medicare payment may be made for a designated health service that is furnished pursuant to a prohibited referral.

(d) *Refunds.* An entity that collects payment for a designated health service that was performed under a prohibited referral must refund all collected amounts on a timely basis, as defined in §1003.101 of this title.

(e) *Exception for certain entities.* Payment may be made to an entity that submits a claim for a designated health service if—

(1) The entity did not have actual knowledge of, and did not act in reckless disregard or deliberate ignorance of, the identity of the physician who made the referral of the designated health service to the entity; and

(2) The claim otherwise complies with all applicable Federal laws, rules, and regulations.

[66 FR 958, Jan. 4, 2001]

### §411.354 Financial relationship, compensation, and ownership or investment interest.

(a) *Financial relationships.* (1) *Financial relationship* means—

(i) A direct or indirect ownership or investment interest (as defined in paragraph (b) of this section) in any entity that furnishes DHS; or

(ii) A direct or indirect compensation arrangement (as defined in paragraph (c) of this section) with an entity that furnishes DHS.

(2) A *direct* financial relationship exists if remuneration passes between the referring physician (or a member of his or her immediate family) and the entity furnishing DHS without any intervening persons or entities (not including an agent of the physician, the immediate family member, or the entity furnishing DHS).

(3) An *indirect* financial relationship exists under the conditions described in paragraphs (b)(5) and (c)(2) of this section.

(b) *Ownership or investment interest.* An ownership or investment interest may be through equity, debt, or other means, and includes an interest in an entity that holds an ownership or investment interest in any entity that furnishes DHS.

(1) An ownership or investment interest includes, but is not limited to, stock, partnership shares, limited liability company memberships, as well as loans, bonds, or other financial instruments that are secured with an entity's property or revenue or a portion of that property or revenue.

(2) An ownership or investment interest in a subsidiary company is neither an ownership or investment interest in the parent company, nor in any other subsidiary of the parent, unless the subsidiary company itself has an ownership or investment interest in the parent or such other subsidiaries. It may, however, be part of an indirect financial relationship.

(3) Ownership and investment interests do not include, among other things—

(i) An interest in a retirement plan;

(ii) Stock options and convertible securities until the stock options are exercised or the convertible securities are converted to equity (before this time they are compensation arrangements as defined in paragraph (c) of this section);

(iii) An unsecured loan subordinated to a credit facility (which is a compensation arrangement as defined in paragraph (c) of this section); or

(iv) An "under arrangements" contract between a hospital and an entity owned by one or more physicians (or a group of physicians) providing DHS "under arrangements" to the hospital.

(4) An ownership or investment interest that meets an exception set forth in §§411.355 or 411.356 need not also meet an exception for compensation arrangements set forth in §411.357 with respect to profit distributions, dividends, interest payments on secured obligations, or the like.

(5) *Indirect ownership or investment interest.* (i) An indirect ownership or investment interest exists if—

(A) Between the referring physician (or immediate family member) and the entity furnishing DHS there exists an unbroken chain of any number (but no fewer than one) of persons or entities having ownership or investment interests between them; and

(B) The entity furnishing DHS has actual knowledge of, or acts in reckless disregard or deliberate ignorance of, the fact that the referring physician (or immediate family member) has some ownership or investment interest (through any number of intermediary ownership or investment interests) in the entity furnishing the DHS.

(ii) The entity furnishing DHS need not know, or act in reckless disregard or deliberate ignorance of, the precise composition of the unbroken chain or the specific terms of the ownership or investment interests that form the links in the chain.

(c) *Compensation arrangement.* A compensation arrangement can be any arrangement involving remuneration, direct or indirect, between a physician (or a member of a physician's immediate family) and an entity. An "under arrangements" contract between a hospital and an entity providing DHS "under arrangements" to the hospital creates a compensation arrangement for purposes of these regulations.

(1) A compensation arrangement does not include any of the following:

(i) The portion of any business arrangement that consists solely of the remuneration described in section 1877(h)(1)(C) of the Act and in paragraphs (1) through (3) of the definition of the term "remuneration" in §411.351. (However, any other portion of the arrangement may still constitute a compensation arrangement.)

(ii) Payments made by a consultant to a referring physician under §414.65(e) of this chapter.

(2) *Indirect compensation arrangement.* An *indirect* compensation arrangement exists if—

(i) Between the referring physician (or a member of his or her immediate family) and the entity furnishing DHS there exists an unbroken chain of any number (but not fewer than one) of persons or entities that have financial relationships (as defined in paragraph (a) of this section) between them (that is, each link in the chain has either an ownership or investment interest or a compensation arrangement with the preceding link);

(ii) The referring physician (or immediate family member) receives aggregate compensation from the person or entity in the chain with which the physician (or immediate family member) has a *direct* financial relationship that varies with, or otherwise reflects, the volume or value of referrals or other business generated by the referring physician for the entity furnishing the DHS. If the financial relationship between the physician (or immediate family member) and the person or entity in the chain with which the referring physician (or immediate family member) has a direct financial relationship is an ownership or investment interest, the determination whether the aggregate compensation varies with, or otherwise reflects, the volume or value of referrals or other business generated by the referring physician for the entity furnishing the DHS will be measured by the nonownership or

noninvestment interest closest to the referring physician (or immediate family member). (For example, if a referring physician has an ownership interest in company A, which owns company B, which has a compensation arrangement with company C, which has a compensation arrangement with entity D that furnishes DHS, we would look to the aggregate compensation between company B and company C for purposes of this paragraph (c)(2)(ii)); and

(iii) The entity furnishing DHS has actual knowledge of, or acts in reckless disregard or deliberate ignorance of, the fact that the referring physician (or immediate family member) receives aggregate compensation that varies with, or otherwise reflects, the value or volume of referrals or other business generated by the referring physician for the entity furnishing the DHS.

(d) *Special rules on compensation.* The following special rules apply only to compensation under section 1877 of the Act and these regulations in subpart J of this part.

(1) Compensation will be considered "set in advance" if the aggregate compensation or a time-based or per unit of service-based (whether per-use or per-service) amount is set in advance in the initial agreement between the parties in sufficient detail so that it can be objectively verified. The payment amount must be fair market value compensation for services or items actually provided, not taking into account the volume or value of referrals or other business generated by the referring physician at the time of the initial agreement or during the term of the agreement. Percentage compensation arrangements do not constitute compensation that is "set in advance" in which the percentage compensation is based on fluctuating or indeterminate measures or in which the arrangement results in the seller receiving different payment amounts for the same service from the same purchaser.

(2) Compensation (including time-based or per unit of service-based compensation) will be deemed not to take into account "the volume or value of referrals" if the compensation is fair market value for services or items actually provided and does not vary during the course of the compensation agreement in any manner that takes into account referrals of DHS.

(3) Compensation (including time-based or per unit of service-based compensation) will be deemed to not take into account "other business generated between the parties" so long as the compensation is fair market value and does not vary during the term of the agreement in any manner that takes into account referrals or other business generated by the referring physician, including private pay health care business.

(4) A physician's compensation may be conditioned on the physician's referrals to a particular provider, practitioner, or supplier, so long as the compensation arrangement—

(i) Is fixed in advance for the term of the agreement;

(ii) Is consistent with fair market value for services performed (that is, the payment does not take into account the volume or value of anticipated or required referrals);

(iii) Complies with an applicable exception under §§411.355 or 411.357; and

(iv) Complies with the following conditions:

(A) The requirement to make referrals to a particular provider, practitioner, or supplier is set forth in a written agreement signed by the parties.

(B) The requirement to make referrals to a particular provider, practitioner, or supplier does not apply if the patient expresses a preference for a different provider, practitioner, or supplier; the patient's insurer determines the provider, practitioner, or supplier; or the referral is not in the patient's best medical interests in the physician's judgement.

[66 FR 958, Jan. 4, 2001]

EFFECTIVE DATE NOTE: At 66 FR 958, Jan. 4, 2001, §411.354 was added, effective Jan. 4, 2002. At 66 FR 60154, Dec. 3, 2001, the effective date of the last sentence in §411.354(d)(1) was delayed from Jan. 4, 2002, until Jan. 6, 2003.