

Health Law ADVISORY

Current legal insights for health care executives

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Julie A. Knutson, Editor

Fast Away the Old Year Passes... A Look Ahead to 2007

As we turn the calendar on 2006, it is time to pause, collect ourselves, and ask what lies ahead. The good news is that we've all survived 2006, an extremely challenging year for hospitals and the health care industry as a whole. Reimbursement pressures placed further strain on hospital-physician relationships. Quixotic regulation of the industry made even the simplest transactions complex. Incentives and structure commonplace in other industries are taboo in health care. Many government requirements continue to go unfunded.

With that said, hospitals, physicians, and other providers and suppliers seem to adapt, problem solve, and sometimes even thrive in this exceptionally challenging environment.

The purpose of this article is to identify several of the big hurdles we expect our clients will face in 2007. We are also soliciting suggestions as to the challenges, subjects or themes you would like to see explored through the Health Law Advisory or in educational programming provided by Baird Holm LLP during 2007.

Here is what we see as the prescription for sleepless nights in 2007 – the lineup of subjects certain to tax provider resources and management ingenuity.

1. Federal Attention to Medicaid Integrity Intensifies

The Deficit Reduction Act of 2005 (DRA) provided the resources to the Centers for Medicare and Medicaid (CMS) to

establish the Medicaid Integrity Program (MIP). The MIP is the first national strategy to detect and prevent Medicaid fraud and abuse in the 41-year history of the Medicaid program. The MIP will be lead by the Center for Medicaid & State Operations (CMSO) under the guidance of the Comprehensive Medicaid Integrity Plan. The DRA specifically requires Medicaid contractors to review the actions of Medicaid providers, conduct audits, identify overpayments and educate providers and others on payment integrity and quality of care.

Congress appropriated additional funds to CMS to employ 100 full time employees to provide support to state agencies for this initiative. Funding for this program will reach \$75 million dollars annually by FY 2009 and for each year thereafter. The Plan states that CMSO plans to initially focus on the following areas: (a) nursing and personal care such as fraud related to long-term care facilities and home health agencies, (b) the provision of prescription drugs to beneficiaries and the underlying costs of those drugs as reported to the States, (c) durable medical equipment and other medical suppliers, and (d) improper claims for payment from hospitals and individual practitioners. A more detailed work plan focused on Medicaid will be developed and published in the coming months.

We anticipate heightened enforcement of Medicaid regulations and recoupment of Medicaid overpayments. It will be important to assess Medicaid compliance

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risk along with other sources of compliance risk and to assure that providers and program/department managers are thoroughly familiar with the Medicaid requirements for payment for services -- which sometime vary importantly from Medicare requirements.

2. Physician Compensation Challenges

For hospitals this means structuring physician compensation that is in line with physician expectations and consistent with public and exempt hospital constraints. Physicians increasingly want to be paid for responsibilities that historically were uncompensated as a component part of medical staff responsibility. Moreover, employed physicians increasingly want their income to mimic that of their peers in private practice, requiring consideration of novel compensation systems. Hospitals are pushing for greater reliance on incentive compensation to promote productivity; physicians desire greater certainty and security. The determination of reasonable compensation and fair market value for services is an ongoing challenge, particularly when discrete services such as call-pay are involved. In 2007, we expect to see substantial redesign and renegotiation of physician compensation methodologies in hospital and hospital-clinic settings.

For physicians and clinic systems, the tension often means looking for ways to “grow the pie” so there is more money to distribute. Private physicians may feel pressure to affiliate and integrate in order to create provider-based status with potentially higher reimbursement, but with complications and loss of autonomy. Community hospitals and physicians will surely be looking for strategies to produce more revenue in the physician clinic setting.

In 2007, we expect physicians and hospitals to re-examine compensation strategy and business structure. And always there looms over the discussion the regulatory triumvirate – Stark, anti-kickback, and tax-exempted or public hospital rules.

3. The Cost-Cutting Imperative.

Hospitals, particularly non-critical access hospitals, must drive down costs. One problem facing hospital CEOs is that hospitals lack control over many components of their cost. Often, it is admitting, attending, and consulting physicians that drive costs, and they may

have no reason (and sometimes good reason not to) to alter practice styles. In any other industry, the solution would be straight-forward – the party incurring cost would provide financial incentives to the party driving the costs to reduce costs through measures that both could agree did not harm the interests of either (in health care – not harmful to patients or patient care.) Enter the Office of Inspector General with its “gainsharing” bulletin and highly restrictive interpretation of Section 1128A(b) of the Social Security Act.

That Act is benign on its face – it prohibits a hospital from paying a physician to reduce or limit services to patients under the physician’s care, and it prohibits the physician from accepting any payments for doing so. As interpreted and applied by the OIG, however, the text means that even programs that positively benefit patients or that are backed up by safeguards assuring no detrimental effect on patients may be prohibited. Several Advisory Opinions have not provided any encouragement of the type of program an average hospital might deploy to incent reductions in cost.

We expect many hospitals to face enormous cost-cutting pressure, and therefore to necessarily look to the most fruitful sources of cost savings -- cost-cutting activities involving cooperation between hospitals and physicians. We anticipate accelerating discussion between hospitals and physicians regarding what is possible and how collaborative cost-saving arrangements may be structured within existing guidance on gain-sharing.

4. The Illusive Technical Component.

During the last several years there has been a growing trend to shift the technical component of service out of hospitals and into physician-owned or co-owned ventures. The most notable example is the specialty hospital, but there are myriad examples of other free-standing or physician-practice – based ancillaries that once were the province of the community hospital. Physicians are in a unique position to profit, since they invariably control some or all of the referrals for these “downstream” businesses. Physicians are therefore logically pressured to consider these ventures, because it means capturing or recapturing often sizable profits that otherwise are referred away.

Such ventures are sometimes facilitated

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by promoters ready to make downstream investing “hassle free,” to enter into free-standing businesses to capture this ancillary revenue. This trend poses tremendous challenges and strains on the hospital-physician relationship at the community level, since profits realized in free-standing ventures represent profits lost to the community hospital.

The upswing in free-standing ancillaries has attracted congressional, CMS, and OIG scrutiny. We therefore anticipate legislative and regulatory initiatives to reduce the financial advantages of free-standing ventures and to increase scrutiny as to the medical necessity of the investor-referred services. This promises to be an extremely fluid area.

5. Cost Report Allocations for CAHs.

Critical access hospital status provides a life-saving advantage to many smaller hospitals, but the status comes with strings attached. Each hospital entering the CAH program evolved to meet its community's unique needs. Each CAH thus starts with a unique array of health care programs and services designed to serve the community. Increasingly, CAHs are facing the issue of heavy cost allocation to non-reimbursable activities (meaning non-CAH activities).

On the surface, this seems fair. The critical access program is intended to cover costs associated with defined actual access “hospital” services, not every type of service a local hospital might be involved in. The problem is in the correct amount of cost to allocate to these non-reimbursable cost centers. Hospitals often say they believe excessive costs are being allocated to these non-reimbursable programs.

The fix may be in persuading CMS to accept a more fair and reasonable allocation of costs or in divesting non-reimbursable programs and activities. A divesting approach means just that – the divestiture must be complete in fact, not just in form.

As critical access hospitals gain more experience with their cost reports, we expect more and more of them to consider their options to reduce the effect of their cost report allocations.

Summary.

We know this is only a short list of the many issues hospitals, physicians and others in the health care industry will face in 2007.

However, we hope these reflections form a starting point for your 2007 strategic legal planning.

We end the way we began – by soliciting suggestions from our readers of the subjects you believe will need attention in the coming year. We will try to address your suggestions in future articles and programming.

Alex M. (Kelly) Clarke

Complying with the Deficit Reduction Act

While the January 1, 2007, compliance deadline is fast approaching, confusion still surrounds many of the employee education requirements of the Deficit Reduction Act (“DRA”). This article provides answers to questions many of our clients have raised about the DRA.

Do we even have to comply? Isn't the DRA directed to states rather than entities? Section 6032 of the DRA is titled “Employee Education About False Claims Recovery.” Despite the title, these provisions are indeed directed at states rather than health care entities. Essentially, the DRA requires each state to amend its medical assistance plan to include specified language (including certain employee education requirements). Once a state properly amends its medical assistance plan, each subject entity in that state will be obligated to comply with the employee education requirements as part of complying with its provider enrollment agreement. Thus, the DRA regulates subject entities indirectly (via the state) rather than directly.

CMS has clarified that states generally have until March 31, 2007, to amend their plans. The plan of a state that meets this deadline will be retroactively effective on January 1, 2007. This time gap creates a Catch 22 for providers subject to the DRA requirements. While enforcement for non-compliance between January 1 and March 31 seems remote, the best course is to gear up for compliance now.

Are we an entity subject to the DRA or not? Section 6032 speaks to entities that make or receive over \$5 Million per year in Medicaid payments. Because the DRA did not clarify what constitutes an “entity,” the term likely retains its commonly understood meaning – any legal entity recognized under state law, such as a corporation, partnership, LLC, etc.

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CMS published recent guidance construing the term “entity” broadly to accomplish the government’s goals. Under the guidance, if an entity “furnishes items or services at more than a single location or under more than one contractual or other payment arrangement, the provisions of [the employee education requirements] apply if the aggregate payments to that entity meet the \$5,000,000 annual threshold.” CMS indicated that this applies “whether the entity submits claims for payments using one or more provider identification or tax identification numbers.”

CMS is casting a wide net in an effort to require as many entities as possible to comply with the employee education provisions. For DRA purposes, Medicaid receipts of an organization (e.g. a corporation) and all programs operated by or as part of the organization (e.g. the corporation’s home health, SNF, and hospice programs) will be aggregated to determine entity status.

If we are an entity, what do we have to do?

All entities subject to the DRA must “establish written policies for all employees of the entity (including management), and of any contractor or agent of the entity, that provide detailed information about the False Claims Act . . . administrative remedies for false claims and statements . . . any State laws pertaining to civil or criminal penalties for false claims and statements, and whistleblower protections under such laws, with respect to the role of such laws in preventing and detecting fraud, waste, and abuse in Federal health care programs.” Generally, this is a federal mandate (via the state) requiring subject entities to draft policies informing employees, agents, and contractors about false claims and remedies.

What is our obligation as to our employees?

Policies must be updated to include DRA provisions and entities must “disseminate” information about the new policies. Employee handbooks must be updated to include “a specific discussion of [specified anti-fraud and whistleblower laws], the rights of employees to be protected as whistleblowers, and the entity’s policies and procedures for detecting and preventing fraud, waste, and abuse.” An entity need not create an employee handbook if one does not already exist.

There is no requirement to conduct specific employee training on the DRA policies or handbook provisions described above. The DRA requires the establishment of “written policies” that “provide detailed information” about various false claims issues. The focus is on

documents and their dissemination, not training. The original version of the DRA contained an express employee training requirement, but this requirement was deleted from the final version enacted into law.

Who are our agents and contractors? The DRA requires that the written policies also apply to the employees of agents and contractors, but does not specify which agents and contractors. According to recent CMS guidance, an agent or contractor for DRA purposes is one who “on behalf of the entity, furnishes, or otherwise authorizes the furnishing of Medicaid health care items or services, performs billing or coding functions, or is involved in monitoring of health care provided by the entity.”

What is our obligation as to our agents and contractors? Entities may draft the DRA policies in paper or electronic form and disseminate information about its policies to its agents and contractors. In all cases the policies must be “readily available” to all contractors and agents.

The policies must also be adopted by the entity’s contractors and agents. This is a key provision. Each entity must have a system to identify who is and is not an agent or contractor for DRA purposes; which agents and contractors have already adopted the entity’s DRA policies; and which ones, including but not limited to new contractors and agents, must still adopt them. In addition, each entity is advised to revise its compliance program (including but not limited to the program’s contracting policy) to ensure that agents and contractors are incorporated as appropriate.

How do the DRA requirements relate to our existing compliance program? The OIG has published compliance program guidance for hospitals, nursing facilities, and other health care providers. The guidance follows the Federal Sentencing Guidelines’ seven minimum elements of an effective compliance plan. Consistent with the DRA’s mandate that the policies educate employees about the false claims laws, one of the seven elements is the “development and distribution” of the plan. This recognizes that merely writing a compliance plan is not enough; it must actually be distributed for it to have any value. Another element requires “regular, effective education and training programs for all affected employees.” Recent CMS guidance confirmed that subject entities must “establish and disseminate” the DRA policies. Thus, while training is not expressly required, CMS clearly envisions entities making their employees, contractors, and agents

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aware of the false claims policies through an organized communication process which could include training.

If your organization is subject to the DRA, it probably has a compliance program already in place (if it does not, it should implement one at the earliest opportunity). Effective compliance programs include provisions for annual and new hire training regarding compliance. To the extent the written policies required by the DRA are integrated into a compliance program with an appropriate compliance education and training component, this will suffice for DRA purposes. Nothing in the DRA requires a subject entity to modify or expand its distribution or communication of, or training on its compliance materials.

In sum, you do have to draft and disseminate written policies, you do not have to conduct specific DRA training, and we recommend that you incorporate the DRA policies into your existing compliance program.

Let us know how we can help. We can help you incorporate the required provisions into your compliance program and employee handbook. Please feel free to contact us for such assistance or with any questions about the above information.

David W. Tomlinson

Best wishes for a successful and satisfying 2007.

“The future is here. It’s just not widely distributed yet.”

--William Gibson (1948-)

Announcements

Congratulations to Vickie Brady on two counts: Vickie was recently recognized as one of the 2006 “40 under 40” by the Midlands Business Journal. This award annually recognizes the accomplishments of 40 entrepreneurs, business owners, managers and professional men and women under 40 years of age in the Omaha metro area. Vickie was also named to the “Best Lawyers in America®” list joining Kelly Clarke, John Holdenried, Barbara Person, and Julie Knutson of the Health Law Section.

John Holdenried will present, along with Roger Thompson of Seim Johnson Sestak & Quist, “Paying for On-call Coverage of the Emergency Department,” at the Healthcare Financial Management Association (HFMA) 2007 Winter Education Meeting to be held in Kearney, Nebraska on January 18, 2007 at the Holiday Inn Express. Presentation time is 1:15 to 2:15 p.m.

Julie Knutson will also speak at the HFMA Winter Educational Meeting on January 19, 2007, 11:00 a.m.-12:00 p.m. Her topic is “High Impact Compliance Activities for 2007.”

Questions? Ideas?

We welcome your questions, ideas and suggestions.

E-mail jknutson@bairdholm.com and help make the Advisory interactive!

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All attorneys are admitted to practice in Nebraska and Iowa unless otherwise noted.

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MEMBER

LEX MUNDI

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