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FRAUD AND ABUSE NOT JUST A FEDERAL GOVERNMENT ENFORCEMENT ISSUE

In a press release issued by the Blue Cross Blue Shield Association (BCBSA) on May 26, 2010 they announced that anti-fraud investigations had resulted in overall savings and recoveries of more than \$510 million in 2009. This represents a significant increase compared to 2008 and contributed to a three-year average return of \$7 dollars for every \$1 dollar spent on anti-fraud efforts.

“Blue Cross and Blue Shield companies are achieving significant gains in the war against healthcare fraud,” said Scott P. Serota, CEO and president of BCBSA. “Blue companies are actively identifying and pursuing healthcare fraud in partnership with federal and state authorities, law enforcement, and licensing boards. These efforts protect consumers’ healthcare safety and safeguard healthcare affordability. Aggressive anti-fraud investigations help ensure critical healthcare dollars are being spent appropriately.”

The release stated that BCBSA anti-fraud investigators collectively *prevented* more than \$318 million from being paid to fraudulent or erroneous medical claims, an increase of 62 percent over 2008. In addition, the Blues’ efforts resulted in the *recovery* of more than \$192 million that had been paid to fraudulent and abusive claims – an increase of 28 percent from the previous year. Data showed 5,028 complaints were received by BCBS anti-fraud hotlines; 1,044 cases were referred to law enforcement officials; 490 arrests and/or indictments resulted from Blue Plan referrals; and 355 criminal convictions from

referrals in 2009.

CARDIOLOGY IN THE SPOTLIGHT AGAIN

The U.S. Department of Justice announced on May 21, 2010 a settlement with The Health Alliance of Greater Cincinnati and The Christ Hospital in the amount of \$108 million regarding claims that they violated the Anti-Kickback Statute and the False Claims Act by paying unlawful remuneration to doctors in exchange for referring cardiac patients to The Christ Hospital in a pay-to-play scheme.

The DOJ alleged that the hospital, a 555-bed acute care hospital in Mount Auburn, Ohio, “limited the opportunity to work at the Heart Station – an outpatient cardiology testing unit that provides non-invasive heart procedures – to those cardiologists who referred cardiac business to The Christ Hospital. The government further alleged that cardiologists whose referrals contributed at least two percent of the hospital’s yearly gross revenues were rewarded with a corresponding percentage of time at the Heart Station, where they had the opportunity to generate additional income by billing for the patients they treated at the unit and for any follow-up procedures that these patients required.”

The government’s position was that this approach provided inducements to refer “lucrative” cardiac referrals in violation of the Anti-Kickback Statute. In addition, the result of this illegal kickback scheme constituted a violation of the False Claims Act.

The whistleblower in this suit was a cardiologist (Dr. Harry Fry) who formerly worked at The Christ Hospital. He will receive \$23.5 million from the settlement.

Because The Christ Hospital declined to enter into a Corporate Integrity Agreement acceptable to the Department of Health and Human Services, Office of Inspector General (OIG), the OIG did not provide a release of its administrative exclusion authorities and is further evaluating the matter.

IRS SOLICITS COMMENTS ON NEW RULES FOR TAX-EXEMPT HOSPITALS

Notice 2010-39, 2010-24 IRB

IRS has asked for comments on implementing the new rules for tax-exempt hospitals in the Patient Protection and Affordable Care Act (Affordable Care Act, P.L. 111-148). The new rules, in Code Sec. 501(r), call for these hospitals to: conduct community needs assessments; establish a financial assistance policy and an emergency care policy; not bill for emergency care for those qualifying for financial assistance at a rate that's more than the amounts generally billed to insured individuals; and forego extraordinary actions against individuals without first making reasonable efforts to determine whether they are eligible for assistance under the hospital's financial assistance policy. Comments referencing Notice 2010-39 should be submitted by July 22, 2010.

Hospitals affected. The new requirements generally are effective for tax years beginning after Mar. 23, 2010 (except as otherwise noted below), and apply to: (1) an organization operating a facility required by a State to be licensed, registered, or similarly recognized as a hospital; and (2) any other organization that IRS determines has the provision of hospital care as its principal function or purpose constituting the basis for its Code Sec. 501(c)(3) exemption. (Code Sec. 501(r)(2)) Because the new rules apply on a facility-by-facility basis, if a hospital organization operates more than one

hospital facility, the Code Sec. 501(r) additional requirements must be met separately for each facility.

IRS specifically requests comments on Code Sec. 501(r)(2)(B)(ii), which provides that an organization operating more than one hospital facility won't be treated as described in Code Sec. 501(c)(3) with respect to any facility for which the requirements are not separately met, including the tax consequences of a failure for some, but not all, facilities and the proper tax treatment in future periods in such a case.

Community health needs assessment (CHNA). For tax years beginning after Mar. 23, 2012, a hospital organization must conduct a CHNA every three years and adopt an implementation strategy to meet the community health needs identified through the assessment. The CHNA must (1) take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health and (2) be made widely available to the public. (Code Sec. 501(r)(3)) The CHNA may be based on current information collected by a public health agency or non-profit organizations and may be conducted together with one or more organizations, including related organizations. (Joint Committee on Taxation's Technical Explanation of the Affordable Care Act (JCT Explanation)) IRS specifically requests comments on appropriate requirements for a CHNA.

Hospital organizations must include in their annual information return (i.e., Form 990) a description of how they are addressing the identified CHNA needs and a description of any needs that are not being addressed and why. (Code Sec. 6033(b)(15)(A)) Under Code Sec. 4959, effective for failures occurring after Mar. 23, 2010, failure to meet the CHNA requirements results in a \$50,000 excise tax, which under Code Sec. 6033(b)(10), must be reported by the hospital organization.

Financial assistance/emergency medical care policy. Under Code Sec. 501(r)(4), hospital organizations must establish a financial assistance policy and a policy relating to emergency medical care. They must have a written financial assistance policy that includes:

- eligibility criteria for financial assistance, and whether such assistance includes free or discounted care;
- the basis for calculating amounts charged to patients;
- the method for applying for financial assistance;
- for an organization without a separate billing and collections policy, the actions it may take in the event of nonpayment, including collections action and reporting to credit agencies; and
- measures to widely publicize the policy within the community served by the organization. (Code Sec. 501(r)(4)(A))

A hospital organization also must have a written policy requiring it to provide, without discrimination, care for emergency medical conditions to individuals regardless of their eligibility under the financial assistance policy described above. (Code Sec. 501(r)(4)(B)) The policy must prevent discrimination, including denial of service, against those eligible for financial assistance under the facility's financial assistance policy or those eligible for government assistance. (JCT Explanation)

Limitation on charges. A hospital organization must limit amounts charged for emergency or other medically necessary care provided to individuals eligible for assistance under the organization's financial assistance policy to not more than the amounts generally billed to individuals who have insurance covering such care. Gross charges also are prohibited. (Code Sec. 501(r)(5)) The JCT Explanation says Congress intended that amounts billed to those who qualify for financial assistance may be based on either the best, or an average of the three best, negotiated commercial rates, or Medicare rates.

Billing and collection. A hospital organization must forego extraordinary collection actions (e.g., lawsuits, liens on residences, arrests, body attachments, or other similar collection processes) against individuals before the organization has made reasonable efforts to determine whether they are eligible for assistance under the hospital organization's financial assistance policy. (Code Sec. 501(r)(6), JCT Explanation) Reasonable efforts include notification by the hospital of its financial assistance policy upon admission and in written and oral communications with patients regarding their bills, including invoices and telephone calls, before collection action or reporting to credit agencies is initiated. (JCT Explanation) IRS specifically asks for comments on what constitutes "reasonable efforts."

The Notice can be viewed on the IRS website at <http://www.irs.gov/pub/irs-drop/n-10-39.pdf>.

The above summary of the IRS issues was provided by the Research Institute of America.

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