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B&B REVIEW

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Healthcare News

December 2007

HAPPY HOLIDAYS

MEDICARE & MEDICAID

New CMS Plan to Link Hospital Pay with Performance on Quality Measures

On November 21, the Centers for Medicare & Medicaid Services issued to Congress their report on the Medicare Hospital Value-Based Purchasing ("VBP") Program. The report outlines how Medicare hospital payments could be linked to quality of care measures.

The plan proposes to reduce payments to hospitals by up to five percent, and then allow hospitals to "buy back" those funds by performing well on certain quality measures.

A copy of the report can be found at: http://www.cms.hhs.gov/AcuteInpatientPPS/downloads/HospitalVBPPlanRTCFINALSUBMITTED2007.pdf

Federal District Court in Alabama Remands Plaintiffs' State Law Claims Alleging Health Insurer Fraudulently Sold Medicare Advantage Plan

An action brought against a health insurer by individuals asserting they were fraudulently induced to enroll in the insurer's Medicare Advantage ("MA") plan was remanded to state court by a U.S. District Court in Alabama. The Court ruled state common law claims were not preempted by applicable Medicare statutes.

Seven plaintiffs filed an action in state court against Pacificare Life and Health Insurance Co. ("Pacificare") and its agents alleging fraudulent tactics were used to persuade them to enroll in its MA plan, Secure Horizons Direct. The plaintiffs accused Pacificare and its agents of misrepresenting to Medicare recipients that they had to enroll in Secure Horizons Direct under the federal government's new prescription drug program.

The plaintiffs also alleged Pacificare and its agents failed to adequately explain that once enrolled in the Secure Horizons Direct plan, they were disenrolling the plaintiffs from their existing Medicare coverage. (*Harris v. Pacificare Life & Health Ins. Co*., 514 F. Supp. 2d 1280 (M. D. AL 2007)).

FRAUD & ABUSE

Fifth Circuit Affirms Osteopath's Conviction, Sentence for Selling Wheelchair Prescriptions

On October 17, a federal appeals court affirmed the conviction and 10-year sentence of an Oklahoma osteopath for taking part in a scheme to defraud Medicare and Medicaid by selling prescriptions for motorized wheelchairs without seeing patients. (*United States v. Morgan*, 5th Cir., No. 06-20634, 10/17/07).

The U.S. Court of Appeals for the Fifth Circuit held that a reasonable jury could have concluded beyond a reasonable doubt that Linda Morgan took part in a scheme to defraud a healthcare benefit program. The appeals court also determined that Morgan conspired with a durable medical equipment salesman for Rovic Medical Supply to defraud Medicare and Medicaid and ordered Morgan to pay $7.9 million in restitution to Medicare.

Mississippi Couple Pleads Guilty To Fraudulent Billing of Medicare

A Mississippi couple pleaded guilty to healthcare fraud and theft of government funds for falsely billing the Centers for Medicare & Medicaid Services for rehabilitation services in the U.S. District Court for the Northern District of Mississippi. (*United States v. Berry*, N.D. Miss., No. 4:06-CR-00104, pleas announced 11/16/07).

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In November, Johnnie Lee Winfield and his wife, Jennifer Yvonne Berry, both of Greenville, Miss., pled guilty to healthcare fraud, and theft of government funds. As part of their plea arrangement, each agreed to forfeit $458,237 for their role in billing Medicare for evaluations and physical therapy provided by Mr. Winfield's firm, Rehabsource Inc., from December 2003 to May 2005.

In addition to pleading guilty to prosecutors, Jennifer Yvonne Berry agreed to pay damages of approximately $1.4 million that will be contained in a separate civil settlement.

Tax

New IRS Form 990 – What does it mean?

The Internal Revenue Service ("IRS") just released a revised Form 990 "Return of Organizations Exempt from Income Tax" that will be effective beginning in 2009 for the 2008 filing year.

Included in the new Form 990 are four new schedules, of which Schedule H "Hospitals" is of particular importance to healthcare financial management professionals. Schedule H focuses on excessive compensation, insider loans, easement valuations and questionable donations. Additionally, Schedule H requires each facility to provide information in the following areas: (i) aggregate community benefit; (ii) billings and collections; (iii) management companies and joint ventures; and (iv) exempt activities and community benefit. Schedule H has sparked debate over whether bad debt and Medicare shortfall is considered charity care/community benefit. The new Schedule H suggests that, in general, bad debts do not count as charity care. In turn, ABA Taxation and Health Law Sections have requested the IRS to identify a specific percentage of bad debts that may be included as charity care.

The term "community benefit" is interpreted differently by every state with community benefit statutes. Alabama, Georgia and Mississippi each have statutes providing for free care compendium; however, no state discusses bad debt as a community benefit. Alabama and Mississippi do not have statutes that address whether free care is a community benefit, although in each state funds are granted to facilities providing free care. See Ala Code § 22-21-210(2) and Miss. Code Ann. § 41-99-3. In Georgia, the term community benefit is not defined; however, a facility is required to provide information in an annual report regarding the indigent and charity care provided by the facility. See O.C.G.A. § 31-8-1 et. seq.

IRS Issues Exempt Organization Implementing Guidelines

Exempt Organizations Implementing Guidelines for fiscal year 2008, released by the Internal Revenue Service on December 13, show that tax-exempt healthcare organizations will continue to be a significant focus of attention for IRS regulatory and compliance initiatives in the coming year.

The guidelines, which detail the Exempt Organizations Division's plans for examinations and projects during fiscal year 2008, said the division will continue its Form 990 redesign initiative and hospital and executive compensation compliance projects. The division also will issue guidance and regulations on requirements for supporting organizations under the Pension Protection Act, on exemption revocations stemming from excess benefit transactions under I.R.C. § 4958, and on the ongoing Form 990 revision effort.

A copy of the report can be found at: http://www.irs.gov/pub/irs-tege/fy08_implementing_guidelines.pdf

Managed Care

Interlocutory Appeal Granted in U.S. Court in Alabama on Interpretation of Medicare Act

In October, the U.S. District Court for the Southern District of Alabama granted a motion for interlocutory appeal on the question of whether § 1395w-26(b)(3) of the Medicare Act is a complete preemption statute. In this case, the court ruled that at least some of plaintiffs' state law claims were completely preempted. This same court and another district court ruled previously that similar state law claims were not subject to complete preemption. (See *Bolden v. Healthspring of Al, Inc.*, No. 07-413-CG-B (S.D. Ala. 2007); *Harris v. Pacificare Life & Health Ins. Co.*, 514 F. Supp. 2d 1280 (M.D. AL 2007)).

The cases involved lawsuits brought against health insurers by Medicare beneficiaries asserting they were fraudulently induced into enrolling in the insurers' Medicare Advantage plans. (Dial v. Healthspring of Ala, Inc., 2007 WL 3025025 (S.D. Ala. Oct. 15, 2007)).

OIG Says "Preferred Hospital" Arrangement As Part of Medigap Will Not Incur Penalties

In an advisory opinion posted December 10, the Department of Health and Human Services

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Office of Inspector General concluded a proposed arrangement to use a "preferred hospital" network as part of a Medicare Supplemental Health Insurance ("Medigap") policy would not constitute grounds for imposing civil monetary penalties.

The Medigap plan would indirectly contract with hospitals for discounts on the otherwise applicable Medicare inpatient deductibles for its policyholders, and would also, at the time of the next policy renewal, reduce the premium for policyholders using a network hospital for an inpatient stay. OIG said it would not impose administrative sanctions even though the Medigap plan could potentially generate prohibited payments under the anti-kickback statute, if the requisite intent to induce or reward referrals of federal healthcare program business were present.

A copy of the OIG Advisory Opinion can be found at: http://www.oig.hhs.gov/fraud/docs/advisoryopinions/2007/AdvOpn07-15A.pdf

LIABILITY

Patient's Negligence Suit Dismissed For Failing to File Expert Affidavit

The Georgia Court of Appeals held that a patient's claim was for professional negligence, rather than ordinary negligence, and therefore an expert affidavit was required under O.C.G.A. § 9-11-9.1. (*Grady General Hosp. v. King*, 2007 WL 3121243 (Ga. Ct. App. Oct. 26, 2007)).

The Georgia Court of Appeals overturned a trial court refusal to dismiss a patient's negligence suit. The patient sued a hospital and nurse alleging that the nurse gave her the wrong medication. The patient failed to attach an expert witness affidavit as required by Georgia's malpractice statutes, a state appeals court ruled October 26.

Mississippi Court Holds Nursing Home Arbitration Clause Valid

On October 9, a Mississippi Appeals Court upheld the validity of an arbitration clause contained in a nursing home's admission agreement signed by a resident. The arbitration clause applied to negligence claims brought against the facility. (*Community Care Center of Vicksburg v. Mason*, 960 So. 2d 220 (Miss. Ct. App. 2007)).

The Mississippi Court of Appeals said Carolyn C. Mason must arbitrate claims she brought against Community Care Center of Vicksburg LLC d/b/a Heritage House Nursing and Rehabilitation Center and Legacy Healthcare Services Inc., because the agreement was valid and was both substantively and procedurally reasonable.

Court Orders Arbitration of Claims Against Operator of Long-Term Care Facility

The U.S. District Court in Mississippi held that Trinity Mission Health & Rehab of Holly Springs, LLC was entitled to enforce an arbitration agreement signed by Lizzie Bowens at the time her mother was admitted to its long-term care facility.

The daughter had the authority to bind her mother and the agreement was otherwise reasonable, a federal trial court ruled October 22 (*Gulledge v. Trinity Mission Health & Rehab of Holly Springs LLC*, No. 3:07-CV-8, 2007 WL 3102141 (N. D. Miss. Oct. 22, 2007)).

Supreme Court Review Sought of Ruling That Dismissed Failure to Stabilize Claims

The U.S. Supreme Court will likely review a federal appeals court decision that summarily upheld a trial court's dismissal of failure-to-stabilize claims brought under the Emergency Medical Treatment and Labor Act ("EMTALA"). (*Morgan v. North Mississippi Medical Center Inc.*, No. 07-508, petition filed Oct. 15, 2007).

The petition for review urged the high court to review the case because the case conflicts with decisions by other federal appeals courts regarding EMTALA's reach. The petition specifically questioned whether EMTALA's requirement to stabilize emergency medical conditions ends once a patient is admitted.

Georgia Court Revives Suit against Hospital; Physician Might Be Deemed Employee, Agent

The Georgia Court of Appeals overturned a trial court decision dismissing medical malpractice claims against a hospital, because there was some evidence suggesting that a doctor named in the lawsuit could be deemed to be a hospital employee. (*Blackmon v. Tenet Healthsystem Spalding Inc.*, No. A07A1840,2007 WL 2892953 (Ga. Ct. App. Oct. 5, 2007)).

The appellate court called the entry of summary judgment in favor of Tenet Healthsystem Spalding Inc. premature, because Joyce Blackmon, the plaintiff who brought the

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malpractice case against the system and a treating physician, presented evidence that the physician was an "employee" under state law, so that the hospital potentially was liable as a result of an agency relationship.

PRIVACY

Trial Court Erred in Not Considering Prior Release of Protected Health Data

The Georgia Court of Appeals overturned a trial court ruling not to consider whether the protected health information ("PHI") of a deceased man who was the subject of a malpractice claim had already been made public. (*Austin v. Moreland*, No. A07A1206, 2007 WL 2937564 (Ga. Ct. App. Oct. 10, 2007)).

The appellate court overturned a temporary injunction restricting the information defendants could receive from other treating physicians. The court remanded the case with orders to consider whether the PHI of a deceased patient, Mr. Moreland, had already been disclosed. If it had, the trial court was charged with determining if that disclosure precluded restricting the PHI in a malpractice action.

Louisiana Court Reinstates Claim against Hospital for Destruction of Medical Records

A Louisiana Appeals Court held that a hospital in Louisiana may be liable for the negligent destruction of patient medical records, because hospitals are required by state law to retain all such records for three years. (*Longwell v. Jefferson Parish Hosp. Serv. Dis.t No. 1,* No. 07-CA-259, 2007 WL 3015260 (La. Ct. App. Oct. 16, 2007)).

The issue arose from the destruction of images related to a medical procedure performed on Karen Longwell. While Longwell and her family could not prove intentional destruction of those documents, they could seek recovery based on a claim of negligent destruction, the court said.

The evidence could have been used by the Longwells to pursue malpractice claims against the hospital after Karen suffered a stroke during a procedure undertaken to address a cerebral aneurysm. The Longwells alleged that without the angiogram records or X-ray images obtained during the procedure, it was impossible for them to prosecute their malpractice claims.

COMMENTARY

DHS Identifies "Chemicals of Interest" Registration Deadline Set for Affected Facilities

On November 20, the Department of Homeland Security ("DHS") published the final list of "chemicals of interest" for the agency's anti-terrorism standards for chemical facilities. This final list came at the end of a year that has seen sweeping changes to security regulations for the chemical industry.

In April, DHS issued the Chemical Facility Anti-Terrorism Standards ("CFATS") in order to identify, assess, and ensure effective security at "high-risk chemical facilities." Those facilities identified as "high-risk" will be required to submit a "Top Screen" registration. While the new regulations require immediate participation by certain facilities, such as chemical manufacturing, storage and distribution facilities; petroleum refineries, and liquefied natural gas, storage (peak shaving) facilities, which DHS has contacted either directly or through Federal Register notice, they also have the potential to apply far beyond the chemical industry.

In addition to the types of facilities identified above that are required to submit Top Screen registration, every facility that possesses any chemical in an amount at or above its "screening threshold quantity" ("STQ") must file a Top-Screen registration at DHS by Tuesday, January 22, 2008. The breadth of these new requirements could impact any number of industries, from hospitals and medical facilities, to food and beverage processors and manufacturers, to high school and university laboratories, based on the quantity of the regulated chemicals they carry. It is estimated that over 7,000 facilities will be considered "high risk."

DHS identified the types and quantities of chemicals subjected to preliminary screening and heightened security by focusing on three main security issues. First, DHS examined the quantities of toxic, flammable, or explosive chemicals that have the potential to create significant adverse consequences for human life or health if intentionally released or detonated. Second, they looked at chemicals that have the potential, if stolen or diverted, to be used or converted into weapons. Finally, DHS identified chemicals that, if mixed with other readily available materials, have the potential to create significant adverse consequences for human life or health.

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DHA has published a list of chemicals that are commonly used in fertilizers, explosives and many industrial applications. Those on the list include ammonia, chlorine, chloroform, ethylene, ethylene oxide, hydrogen peroxide, nitric acid, nitric oxide, propane, sodium nitrate and hundreds of others. DHS has identified chemicals and established the specific amounts for STQs and preliminary screening based on their potential to create significant human life or health consequences. DHS has provided instructions on how to measure chemicals found in solutions or mixtures.

DHS expects tens of thousands of companies and institutions to file Top-Screens. Once a Top Screen assessment is filed, DHS will then notify "covered" facilities, which must prepare security vulnerability assessments and site security plans.

The Top-Screen and certain other documents are "chemical-terrorism vulnerability information" ("CVI"). CVI is subject to additional requirements governing handling, disclosure and who may access it.

Violations of these regulations are subject to an enforcement action by DHS, such as an administrative order and civil penalty.

You can find a copy of the Final Rule and an appendix containing a list of target chemicals at: http://www.dhs.gov/xlibrary/assets/chemsec_appendixafinalrule.pdf

The attorneys of Balch & Bingham are following this matter closely. For more information, please contact Scott Hitch at (404) 962-3553 or shitch@balch.com.

POLITICS AND HEALTHCARE

Presidential Candidates Views on Health Insurance

DEMOCRATS:

Clinton: Mandatory universal coverage in first term. Tax credits for working families to make insurance more affordable -- ensuring premiums do not exceed a percentage of income. Business would be required to offer insurance to employees or pay into a pool for people without it. Expand Medicare and federal employees' health insurance plan to cover those without adequate workplace insurance. Raise taxes on wealthier families to help pay estimated cost of $110 billion a year. Also, raise taxes on a portion of "very generous" plans covering people making more than $250,000.

Edwards: Mandatory universal coverage in first term by expanding system of federal health insurance and family tax credits, and by imposing requirements on employers, insurance companies and individuals. Increase taxes on wealthier families to pay for program's cost of up to $120 billion a year.

Obama: Mandatory coverage for children. Aim for universal coverage by requiring employers to share costs of insuring workers and by offering coverage similar to that in plan for federal employees. Says package would cost up to $65 billion a year after unspecified savings from making system more efficient. Raise taxes on wealthier families to pay the cost.

Richardson: Tax breaks for businesses and for people who pay for their own coverage. Lower the eligibility age for Medicare to 55 and expand programs for poor and children. Package could cost up to $110 billion a year. Claims savings from expanded spending on preventive care would help achieve mandatory universal coverage without tax increases.

REPUBLICANS:

Giuliani: Income tax deduction of $7,500 per taxpayer to defray insurance costs. Tax credit for poorer workers to supplement Medicaid and employer contributions as part of "market-driven" expansion of affordable coverage. Expanded use of health savings accounts. No mandate for universal coverage.

Huckabee: Favors market solutions, state innovation. "We don't need universal healthcare mandated by federal edict or funding through ever-higher taxes." Spend more on prevention and research.

McCain: $2,500 refundable tax credit for individuals, $5,000 for families, to make health insurance more affordable. No mandate for universal coverage. In gaining the tax credit, workers could not deduct the portion of their workplace health insurance paid by their employers.

Romney: Incentives for states to expand affordable coverage. As governor, he signed healthcare law aimed at ensuring universal coverage through a mix of subsidies, sliding scale premiums and penalties for those who do not get insurance.

Thompson: "Market-driven" expansion of affordable coverage, but no mandate.