

HEALTH LAW ALERT
SPRING 2009

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ATTENTION TAX-EXEMPT HOSPITALS:
HOSPITAL COMPLIANCE PROJECT FINAL REPORT RELEASED

On February 12, 2009, the IRS released its Hospital Compliance Project Final Report, which is the culmination of an IRS study begun in 2006 with a questionnaire sent to about 500 nonprofit hospitals. Key findings in the Report with respect to its two major areas of inquiry, community benefit, and executive compensation include:

- A significant percentage of all types and sizes of hospitals in the survey would fail to satisfy a "bright line" exemption standard requiring uncompensated care expenditures of at least 3 percent of total revenues, or aggregate community benefit expenditures of at least 5 percent of total revenues
- "High levels of compliance" with the rebuttable presumption procedure used to establish executive compensation at the reporting hospitals

More significantly, the report provides an indication of what's next:

- The IRS is interested in the impact of the rebuttable presumption procedure, including the effect the use of for-profit comparables and the initial contract exception are having on executive compensation levels, and the effect the procedure has on the IRS' ability to challenge compensation paid by tax-exempt organizations
- "Particular areas of inquiry" going forward are expected to include:
 - o Accuracy of costing methodologies used to measure community benefit
 - o Medical research funded by for-profit organizations or not made widely available to the public
 - o Amounts reported as bad debt that are actually attributable to charity care
 - o Treating portions of Medicare shortfalls or certain community building activities as community benefit
 - o Review of nonquantifiable aspects of community benefit

The full report is posted online at: <http://www.irs.gov/charities/charitable/article/0,,id=203109,00.html>.

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AG FOCUSES ON HEALTH CARE PROVIDERS' COLLECTION ACTIVITIES

BY CATHERINE BITZAN

The Minnesota Attorney General's office has recently turned its attention to the collection activities of health care providers. On January 22, 2009, Minnesota Attorney General Lori Swanson filed suit against Allina Health System, alleging that the provider violated Minnesota law by charging up to 18 percent interest on patients' medical debts and failing to fully disclose debt financing terms to patients. The suit may be an indication of greater scrutiny by the AG of health care providers' debt financing programs and the unique issues they raise under Minnesota law.

Does An 8 Percent Interest Rate Cap Apply?

The AG complaint alleges that Allina's MedCredit financing program violates Minnesota usury law by charging patients interest rates in excess of 8 percent on their medical debts. The MedCredit program offers Allina patients the option to finance the portion of their health care costs not covered by insurance, charging interest rates on a sliding scale of 8 percent, 12 percent, or 18 percent based on the balance due.

The allegations raise the question of whether MedCredit constitutes an "open-ended" credit plan under Minnesota law. Programs that provide financing on an ongoing basis, known as "open-ended" credit, may charge interest rates of up to 18 percent under Minnesota Statutes Section 334.16. In contrast, Minnesota Statutes Section 334.01 imposes an 8 percent cap on interest rates charged on "closed-end" credit plans. Allina maintains that MedCredit is an open-ended credit plan because patients are allowed to use MedCredit financing for subsequent care. However, the AG has taken the position that debt financing programs such as MedCredit do not extend credit at all, but merely service and collect debt for providers, and are therefore subject to the 8 percent interest cap.

Are You Violating the Consumer Fraud Statute?

The AG has also taken the position that Allina's debt collection practices violate the Minnesota Consumer Fraud Act. The complaint alleges that Allina's portrayal of MedCredit as an open-ended credit program constitutes false pretenses in violation of Minnesota Statutes Section 325F.69. The AG also alleges that MedCredit does not allow patients to consolidate debt unless they qualify under a mandatory approval process, and that Allina materially misrepresented to patients their ability to add additional medical debts to their MedCredit accounts. Finally, the AG argues that Allina's failure to fully disclose terms and interest rates on its debt financing program to patients amounts to deceptive practices. These allegations indicate that the AG is particularly interested in the level and method of disclosures given to patients regarding medical debt financing programs.

Steps You Can Take Now

In light of the AG's recent inquiry into the debt financing programs of health care providers, we recommend that providers scrutinize whether their programs are similarly open to challenge. Because of the lack of clarity regarding whether these types of medical debt financing plans are subject to the 8 percent interest rate cap, we recommend charging no more than 8 percent annual interest on patient medical debts. Providers should also examine the processes they use to ensure that patients are fully informed of the nature, terms, and interest rates of provider-affiliated debt financing plans, and may consider implementing a "best practices" approach to full disclosure of these terms to patients. With an increasing media focus on the role of health care costs in current economic times, the AG appears inclined now more than ever to examine health care debt collection practices. Implementing these steps immediately may help decrease the likelihood that the AG will turn its attention to yours.



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MINNESOTA LEGISLATORS EXPECTED TO ESTABLISH STATE FALSE CLAIMS ACT

BY BRIAN DILLON AND SARAH DUNIWAY

The Minnesota State Legislature is considering a bill that would codify a state equivalent of the federal False Claims Act (FCA). House Bill 8 / Senate Bill 82 is likely to pass this session because it addresses an issue of interest to legislators and also includes federal incentive funding. Although not limited to health care, this legislation would undoubtedly have major ramifications for health care providers in Minnesota. In fiscal year 2007 alone, the U.S. Department of Justice recovered more than \$2 billion in settlements and judgments under the federal FCA, and, continuing a recent trend, more than three-quarters of that amount came from providers accused of submitting fraudulent claims for reimbursement under federal health care programs.

Because most of the conduct covered by the Minnesota bill is already illegal under the federal FCA, the primary significance of a state version is jurisdictional. The bill moves these cases into state courts, which are generally seen as more accessible than the federal courts. The Minnesota Attorney General would have primary enforcement authority for state false claims, in addition to the federal Department of Justice authority for federal claims. Additionally, the Attorney General's authority to investigate would require only a reasonable ground for believing that a person has violated, or is about to violate, the FCA. Moreover, private plaintiffs (called qui tam plaintiffs) would also have the authority to sue for and recover damages and civil penalties on behalf of a state or local government agency, with a portion going to the plaintiff individually.

From a substantive standpoint, like its federal counterpart, Minnesota's FCA would give state and local government agencies, as well as private qui tam plaintiffs acting on their behalf, the authority to seek damages (as much as three times the amount of the actual damages sustained) and civil penalties (anywhere from

\$5,500 to \$11,000 per false claim) from anyone who submits a false or fraudulent claim for payment to such agencies. A "claim" means any request for payment or property if the state would provide a portion of the money or property requested, or if the state would reimburse someone else for the money or property requested.

In most cases, Minnesota's FCA would impose liability on any person who:

- "Knowingly" presents a false or fraudulent claim for payment or approval to a state officer or employee
- "Knowingly" makes or uses a false record or statement to get a false or fraudulent claim paid or approved by the state

Importantly, a person needs not intend to defraud the government in order to be liable. Instead, to act "knowingly" means to have actual knowledge of the false information or to act in deliberate ignorance or reckless disregard of the truth or falsity of the information. In the health care context, FCA claims are typically brought under these same standards against providers who allegedly sought reimbursement for services: (a) that were never provided; (b) that were not medically necessary; (c) that were not eligible for reimbursement; or (d) without adequate documentation of the services provided or time spent performing those services.

The proposed legislation includes a unique provision that should give health care providers even more reason to pay attention. Specifically, the bill would impose liability on the "beneficiary of an inadvertent submission of a false claim [who], after discovering the falsity of the claim, fails to disclose the falsity to the state within a reasonable time." The original bill required such disclosure within



30 days of discovery, but that time limit was removed in at least one version of the bill. In any event, the escalation of an inadvertent mistake to a false claim because of a failure to disclose within an undetermined "reasonable" time period introduces a new urgency for Minnesota health care providers to have systems that prevent, detect, correct, and potentially self-disclose instances of non-compliance with billing rules.

Finally, one version of the measure includes a retroactivity provision that would allow the government and/or private plaintiffs to bring civil actions and recover damages related to activity that occurred prior to the effective date of the law.

Of course, the legislative process is dynamic, and additional amendments are likely as the bill moves through that process.



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HEALTH INFORMATION TECHNOLOGY, PRIVACY, & SECURITY UNDER THE FEDERAL STIMULUS PACKAGE

BY GERALD "JUD" DELOSS

The Federal Government's stimulus package, the American Recovery and Reinvestment Act of 2009, provides many benefits and some new restrictions on physicians, hospitals, nursing facilities, educational institutions, and vendors. The Act provides some new sources of funding for health information technology (HIT). It also provides for grants to educational institutions. The Act provides incentive payments to physicians, hospitals, and nursing facilities for the adoption and implementation of HIT, including electronic health records (EHRs). However, the Act also increases privacy and security protections for health information and entities that may use or access such information.

Health Information Infrastructure

First, EHRs and HIT are to be promoted by the Office of the National Coordinator for Health Information Technology (ONCHIT). ONCHIT was previously created by President Bush by Executive Order. ONCHIT is to oversee HIT Policy and Standards Committees, and its duties include the integration of HIT and the utilization of EHRs for each person in the United States by 2014.

The Secretary of Health and Human Services is to invest in the infrastructure necessary to promote and allow for the electronic exchange and use of health information.

The Secretary may award grants to States to facilitate and expand the electronic exchange and use of health information. Grants may also be made for loans to health care providers to purchase or enhance EHRs or train personnel.

Education

Assistance will be provided to institutions of higher learning through Research Centers and a HIT extension program. HIT Regional Extension Centers are to provide technical assistance and information obtained from the Center to support regional efforts.

The Secretary may award grants to develop academic curricula integrating certified EHRs into clinical education of health professionals.

Separately, the Secretary is to provide assistance to higher education institutions to establish or expand medical health informatics programs, including certification, undergraduate, and masters degree programs for both health care and IT students.

EHR Incentive Payments

Incentives will be provided under the Medicare program for the adoption and meaningful use of certified EHRs. The incentive is to be paid to an eligible professional, including physicians, Medicare Advantage providers, hospitals, Medicaid providers, and nursing facilities. Payment is only made for the "meaningful" use of an EHR, which includes e-prescribing, connection with other EHRs, and reporting of clinical quality measures.

Privacy and Security

Some of the most interesting aspects of the Act relate to the revisions and additions made to privacy and security requirements. While the framework of the Health Insurance Portability and Accountability Act (HIPAA) has been retained, there is broader coverage and increased burdens.

The Act adds privacy and security provisions and a penalty to business associates in the same manner such sections apply to a covered entity. Civil and criminal penalties shall apply to business associates in the same manner as covered entities.

The Act also imposes a heightened notification requirement in the event of a breach. Thus, the covered entity must notify each individual of a breach. Business associates must notify covered entities of breaches, including the identity of any individual involved. There are specific requirements relating to the notice

process. Where more than 500 individuals are involved, the covered entity is required to notify major media outlets and immediately notify the Secretary. If 500 or fewer individuals, then the covered entity must report all breaches to the Secretary at the end of year.

New restrictions are imposed on certain disclosures and sales of protected health information (PHI). If an individual requests a restriction on the use or disclosure of PHI, the covered entity must comply in certain circumstances. Certain communications by a covered entity or business associate about a product or service will now be considered marketing. In addition, a covered entity or business associate may not receive direct or indirect payment in exchange for making any marketing communication without a valid authorization.

Another new term defined is "personal health record" (PHR), which means electronic record of health information on an individual that can be drawn from multiple sources and that is managed, shared, and controlled by or for the individual. Restrictions are imposed on PHR vendors and other non-HIPAA covered entities. Those entities must notify individuals of breaches and also notify the Federal Trade Commission.

Any entity that transmits PHI and is required to routinely access that PHI—such as a Health Information Exchange Organization, Regional Health Information Organization, e-Prescribing Gateway, or each vendor under contract with a covered entity to allow a PHR—is required to enter into a business associate agreement and will be treated as a business associate.



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