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Perspectives on health care legal issues

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Guard your EPHI

CMS releases HIPAA security guidance

The ability to transmit health information through new technology has led to significant improvements in the provision of health care. However, these technological advances may create new data security issues you must address to remain HIPAA compliant.

CMS has prepared security guidance for entities that are covered by HIPAA. It provides information on the risks surrounding remote use of, and access to, Electronic Protected Health Information (EPHI). It also provides mitigation strategies.

Review security policies and procedures

HIPAA requires covered entities, including hospitals, to regularly review their security policies and procedures. The guidance establishes minimum compliance expectations for safeguarding EPHI that is accessed, stored or transported offsite.

While acknowledging that there are situations which warrant offsite use of or access to EPHI, the security guidance stresses that covered entities should be “extremely cautious” about allowing such access.

Therefore, take some time to thoroughly review CMS’s security guidance if your organization allows remote access to EPHI through any of the following media:

- > Portable technology including, but not limited to, laptops, personal digital assistants, home computers, USB flash drives, memory cards, floppy disks, CDs, DVDs, backup media and smart phones, and
- > External systems or hardware not owned or managed by the covered entity, including hotel, library or other public workstations.

The guidance also applies to wireless access points, such as e-mail, smart cards, and picture archiving and communication systems (PACS).

Determine security strategies

As you evaluate your organization’s need for off-site use and access to EPHI, consider four general factors put forth by the security guidance:

1. Size, complexity and capabilities of the covered entity,
2. Technical infrastructure, hardware and software security capabilities,
3. Cost of security measures, and
4. Probability and criticality of potential risks to your EPHI.

Moreover, significant emphasis should be placed on risk analysis and risk management strategies, policies and procedures for safeguarding EPHI, and security awareness and training on those policies and procedures.



Assess risk

To ensure that your health care organization complies with the security guidance, assess its risk related to remote access and use of EPHI, and then draft policies and procedures that cover:

Data access. Grant remote access to EPHI only to authorized users based on their role within your organization.

Storage. Address security requirements in your storage policies and procedures for all media containing EPHI that may be moved beyond your organization’s control.

Transmission. Focus your transmission policies on ensuring the safety of EPHI transferred over networks (both external and internal).

Train all employees

All employees must understand and comply with EPHI protection policies and procedures. Organizations should, therefore, provide training for accessing, storing and transmitting EPHI — including password management protocols, open network transmission guidelines and downloading restrictions (especially on noncorporate computers).

In addition, instruct your employees on how to address security breaches and what actions they

should take to manage the harmful effects of a breach. Moreover, implement a sanctions policy to address any incidents of noncompliance.

CMS's security guidance provides helpful tables that identify specific risks and corresponding risk management strategies that may prove useful to your IT professionals.

Reap the benefits of adherence

The security guidance outlines practical considerations and solutions for improving your data security policies and procedures. Plus, it can help you determine whether the actions of a covered entity are reasonable and appropriate for safeguarding the confidentiality, integrity and availability of EPHI. <

501(c)(3)s get IRS guidance on good governance practices

Earlier this year, the IRS issued the draft guidelines, “Good Governance Practices for 501(c)(3) Organizations,” that reflect various ideas advanced by others within and outside the tax-exempt community. The guidelines start with an overview of the characteristics the IRS believes may be problematic with regard to governing boards, including inappropriately sized boards, toleration of secrecy and neglect, and lack of appropriate expertise.

Even though none of those characteristics are likely to lead to a revocation of tax-exempt status by themselves, it's clear that the IRS believes these characteristics could lead to an environment where impermissible private benefit is likely to occur. The IRS also addressed several areas of corporate governance.

Good governance practices

In light of the IRS's guidelines, hospitals, health systems and other exempt health care entities should review the following areas of

corporate governance with the appropriate leadership groups:

Mission statement. Your board of directors should develop and adopt a clearly articulated mission statement.

Code of ethics and whistleblower policy. Citing public expectation, the guidelines suggest that organizations develop and review annually a code of ethics that defines what types of behavior are encouraged *and* discouraged. The guidelines also encourage governing bodies to adopt policies for handling employee complaints and procedures that allow employees to confidentially report suspected financial impropriety.

Due diligence. The guidelines highlight the “duty of care” that directors owe the exempt organizations they serve. The duty of care requires 1) good faith, 2) prudence and 3) action in the health care organization's best interest. To comply with these guidelines, make sure your directors are familiar with the organization's activities and

financial status, and that they have full and accurate information for decision-making purposes.

Duty of loyalty. The IRS stresses that directors must avoid conflicts of interest. The guidelines advise that exempt organizations adopt a written conflict-of-interest policy that requires directors to act solely in the interest of the organization, and that it include written policies addressing whether certain relationships or interests result in a conflict and describe courses of action in case of a conflict.

Transparency. In light of recent IRS survey results on executive compensation that indicated “significant reporting errors and omissions,” all exempt health care organizations should strive to be as transparent as possible. Specifically, an organization’s Form 990 should be complete and accurate, made public, and possibly be posted to the organization’s Web site.

Fund raising. Fund-raisers should comply with all laws, charge reasonable fees, and have proper oversight.

Financial audits. Your directors should regularly receive and review the organization’s financial statements. Cost permitting, the IRS suggests you use an independent financial professional to review the statements. Moreover, consider having an alternate person periodically examine the financial statements to ensure accuracy.

Compensation practices. A committee of people who don’t have a financial interest in the determination should set director compensation. With regard to officers, the IRS suggests that the organization rely on the rebuttable presumption test of Internal Revenue Code Section 4958 and Treasury Regulation Section 53.4958-6.

Document retention. The guidelines’ final suggestion is to adopt a policy establishing standards for document integrity, retention and destruction.

These guidelines strongly support the view of many tax professionals that good governance is essential to an organization’s ability to comply with tax law and maintain its tax-exempt status. Hospital leadership also should review these guidelines with senior-level executives, their board of trustees and any governance subcommittees.

Stay within the guidelines

Many health care organizations will find that they are already complying with many of these guidelines. But as scrutiny of tax-exempt health care entities continues, the guidelines provide simple ways to ensure your organization has a governance structure in place that will most likely keep it compliant with tax law.

Although charity care and community benefit will remain the primary drivers of your exempt status, the fact that the IRS has published these guidelines — at this time — indicates that it’s looking at your organization’s entire profile. <

Super-PHO faces FTC scrutiny

To obtain access to additional patients, physician groups often sign contracts with health plans and other third-party payors. Although the contract terms may lower reimbursement rates, the access to new patients (as a result of the payor’s relationship with enrollees) can more than compensate for the lower rates.

One particular relationship, however, has caught the eye of the Federal Trade Commission (FTC).

Earlier this year, the FTC issued a final order regarding an antitrust complaint against Advocate Health Partners (AHP) and several local AHP physician health organizations (PHOs). AHP is a “super-PHO” that represents multiple PHOs grouped under the name Advocate Health Care Network. The network operates eight general acute-care hospitals in Chicago.

The problem arose when AHP attempted to collectively negotiate on behalf of some 2,900 physicians in the Chicago area. The FTC accuses

AHP of collective bargaining without any meaningful integration between the individual physician practices, and claims that AHP engaged in price fixing and illegal group boycotts when it refused to deal with both UnitedHealthcare and Blue Cross. The FTC claims that these actions resulted in the AHP physicians receiving above-market reimbursement from payors and increasing consumer prices for physician services.

A history of AHP operations

Before 2001, local PHOs negotiated through AHP for hospital and physician services. Each PHO would set a minimum acceptable rate for fee-for-service contracts and communicate it to AHP, who would then negotiate with third-party payors on behalf of the PHOs. The individually negotiated contracts were sent to each of the local PHOs, which could either accept or reject them.

In 2001, however, AHP changed its process and tried to establish uniform minimum rates across all its PHOs, successfully contracting with at least 12 payors.

Issues with UnitedHealthcare

In April 2001, AHP presented a proposal to UnitedHealthcare (UHC) for physician services. When UHC told AHP that the proposal was “significantly over market” and didn’t counter, AHP terminated all of its hospital and physician contracts with the payor.

UHC continued to negotiate with AHP over hospital rates but also began to solicit individual contracts with AHP’s physicians. When AHP became aware of the soliciting, it threatened to stop negotiations unless UHC stopped soliciting its physicians. UHC eventually agreed to a physician group contract with fees around 20% to 30% higher than its direct contracts with other individual physicians in the area.

Blue Cross joins the fray

Blue Cross had individual contracts with a majority of AHP’s physicians at lower rates than AHP had been able to negotiate with other payors. As part of a strategy to obtain a group



contract with Blue Cross, AHP asked its physicians to sign an “Agency Agreement,” which authorized AHP to negotiate with Blue Cross and cease the payor’s individual contracts.

When negotiations failed, AHP terminated over 1,700 individual contracts with Blue Cross on Oct. 1, 2002, and tried to negotiate a group contract on their behalf. Blue Cross filed a lawsuit against AHP alleging antitrust violations, and the parties eventually settled.

FTC implements sanctions

As a result of the charges of collective bargaining without meaningful integration, price fixing and refusal to deal individually with health plans by competing independent physicians and physician practice groups, the FTC’s final order, in part, 1) prevents AHP from entering into agreements to negotiate on behalf of physicians, 2) requires AHP to terminate its illegally negotiated payor contracts without penalty, 3) requires AHP to notify the FTC if it wants to act as a “messenger” for physicians in the future, and 4) requires AHP to notify physicians and payors of the FTC order.

Carefully negotiate PHO contracts

This FTC final order underscores the need for hospitals and health systems that use PHOs to take care not to engage in prohibited activities when negotiating contracts. <

Diagnostic imaging under fire

The imaging industry continues to take hits. For example, Medicare imaging reimbursement reductions under the Deficit Reduction Act of 2005 took effect Jan. 1, 2007; the U.S. Department of Justice has an ongoing suit against a physician-owned chain of imaging centers in Florida; and at least one state attorney general is questioning certain imaging arrangements for private pay patients.

The latest hit was on Jan. 17, 2007, when Illinois Attorney General Lisa Madigan joined a suit against 11 Chicago-area imaging centers. The suit alleges that illegal kickbacks were paid to physicians to persuade them to refer patients to the imaging centers. As of this writing, no federal charges have been filed and no individual physicians have been charged.

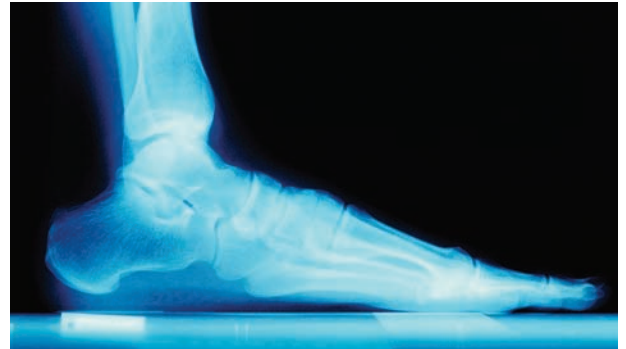
While state antikickback laws aren't necessarily new, many states haven't actively enforced them. With the proliferation of arrangements such as the imaging/physician arrangements addressed by the Illinois case, states may begin using these laws to prosecute questionable arrangements.

How the lawsuit came about

The imaging centers charged in the suit provided the equipment, space, staff and scheduling services. Plus, the imaging centers performed the imaging procedure and used an employed radiologist to interpret the results.

Any industry that grows at the rate imaging has grown is likely to attract scrutiny.

According to the complaint, the referring physicians *didn't* supervise the procedures or interpret the scan. The referring physicians *did* make lease payments to the center (allegedly for \$400 per procedure), presumably for the equipment, space, staff and scheduling services. The referring physicians then billed the insurance company \$800 for



a scan, presumably the standard reimbursement for such imaging procedure. The suit states that the referring physicians received \$800 from the insurance company, making a profit of \$400 after the cost of the lease payment.

Getting to the nuts and bolts

The Illinois attorney general is pursuing several separate, but related, legal claims. The suit alleges that the imaging centers are violating both the Illinois Insurance Fraud Act and the Illinois False Claims Act by inducing referrals by allowing physicians to bill insurance companies for patients that the physicians refer to the centers.

The second claim revolves around the Consumer Fraud and Deceptive Business Practices Act and alleges improper fee splitting and the corporate practice of medicine in violation of the Medical Practice Act.

The person who brought the suit, the owner of a competing imaging center, claims his practice has suffered because he charges more for the same services than the imaging centers being sued. He also claims that the quality of services provided by those imaging centers is affected since they don't receive the full \$800 and are therefore forced to use shoddy equipment and supplies and less-qualified radiologists. The discovery and trial processes may ultimately determine the accuracy of the allegations.

Why it matters to you

Imaging has been one of Medicare's fastest growing costs, rising 20% per year since 1999. In 2006, Medicare spent approximately \$7 billion for imaging scans, according to CMS.

While medical imaging's growing ability to detect health conditions has reduced the need for diagnostic surgery, any industry that grows at the rate imaging has grown in the past several years is likely to attract increased scrutiny.

One of the effects of the attention on the imaging industry may be a reduction in reimbursement for imaging procedures or new regulations limiting physician relationships with imaging centers and entities. With Medicare reimbursement being reduced, it's possible that

private insurers will follow with reductions in payments for certain imaging procedures.

Moving forward

Physicians, hospitals and imaging centers should continue to work to ensure any arrangements they enter into are within the bounds of the federal Stark and antikickback laws — as well as state antikickback and insurance laws — to appropriately minimize potential liability. These oft-overlooked state laws may indeed have teeth, and state attorneys general may begin to bite. <

Noncompete agreements can offer some protection

You've invested time, money and resources into training your physicians, nurses and midlevel providers. So how can you protect your group when a health care professional decides to leave? The answer may lie with a noncompete provision in the professional's employment agreement.

Noncompetes are typically structured to prevent a practitioner from practicing in a particular specialty, within a certain geographic area, for a specific period of time. For example, an agreement can stipulate that a departing professional can't practice within 50 miles of your facility for the next two years.

In most states, enforcement depends on whether the courts determine that the terms of the noncompete — specifically geographic scope and time period — are reasonable. Because the definition of "reasonable" can vary greatly from state to state, it's crucial that you consult an attorney who has knowledge of how your state courts enforce noncompetes.

You can also consider one of these options to protect your practice from departing professionals:

Nonsolicitation clauses. This clause allows departing physicians to practice wherever they like but prevents them from approaching any patients they treated as a member of your group. Be aware, however, that patients may still choose to leave your practice and follow the departing physician. Therefore, if enforceable in your state, noncompetes provide a group more protection than a nonsolicitation clause.

Buyout options. These require a departing physician who wants to practice in your area to pay your practice a predetermined amount. Again, the amount must be reasonable. Buyout options can be seen as a reimbursement to the practice for its investment in hiring, training and supporting the physician during his or her employment.

Get the advice of health care and employment attorneys to help you structure a noncompete or other terms of your employment agreements. It will be time and money well spent.



A message to our clients and friends:

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We understand the value of good information when making sound business decisions. *Practical Health Law* is written by Hall Render's health law attorneys, each with extensive experience handling the legal issues of health care providers. We trust the information in each issue will be a valuable resource. Our attorneys stand ready to respond promptly to your questions and needs; please contact us if there are specific topics you'd like to see addressed.

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