PRACTICAL*HEALTH*LAW

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SEPTEMBER/OCTOBER 2008

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Can prompt pay discounts pass muster with the OIG?

Earlier this year, the Department of Health and Human Services Office of Inspector General (OIG) issued an advisory opinion addressing a health care system's proposed prompt pay discounts for federal health care program beneficiaries and other insured patients. The OIG concluded that, although a prompt payment arrangement could implicate the antikickback statute if the requisite intent to induce referrals were present, the OIG wouldn't impose administrative sanctions in this particular situation. Likewise, the OIG concluded that the arrangement wouldn't constitute grounds for imposing civil monetary penalties.

THE PROPOSED ARRANGEMENT

The facts giving rise to the advisory opinion are fairly straightforward. The health care organization owned and operated three hospitals. Under its proposed prompt payment arrangement, the organization would offer federal health care beneficiaries and all other insured patients a discount for prompt payment of cost-sharing amounts and amounts owed for noncovered services. The organization would offer a prompt pay discount for both inpatient and outpatient services, regardless of patient financial status or ability to pay.

> *For outpatient services, the OIG analyzed whether the prompt pay discount could be a disguised payment for referrals.*

A patient would learn about the prompt pay discounts only at certain times during the health system's ordinary course of dealing with patients, including:

- When the patient registers for outpatient services and the patient pays his or her cost-sharing amount,
- When the health system sends written statements to patients by mail, and
- When financial arrangements are made between the health system and the patient after admission for inpatient health services.

The arrangement would be designed to reduce the organization's accounts receivable and cost of debt collection, boosting cash flow. Specifically, the amount of the discount (5% to 15%) would bear a reasonable relationship to the amount of collection costs that it would avoid. The actual size of the discount would depend on both the timing of payment and the patient's remaining balance.

THE OIG ANALYSIS

The OIG analyzed the discount for inpatient services under the safe harbor for waivers of coinsurance and deductibles. The organization certified that the proposed arrangement would comply with all three conditions for this safe harbor:

1. The organization wouldn't claim the discount as debt or otherwise shift burden to Medicare or Medicaid programs, other third-party payors or individuals.

2. The organization would offer the discount without regard to the reason for the patient's admission, length of stay, diagnostic-related group or ambulatory payment classification.
3. The discount wouldn't be part of a price reduction agreement between the organization and a third-party payor.

Based on these factors, the OIG concluded that discounts for inpatient services would comply with the safe harbor.

For outpatient services, the OIG analyzed whether the prompt pay discount could be a disguised payment for referrals. The OIG concluded that the proposed arrangement wouldn't subject the organization to administrative sanctions, nor would it give rise to civil monetary penalties for beneficiary inducement, based on four factors:

1. The organization certified that it wouldn't advertise the prompt pay discount.
2. The organization would notify other third-party payors of its prompt payment policies.
3. All the costs of the proposed arrangement would be borne by the organization.
4. The organization certified that the discounted fee amount would bear a reasonable relationship to the amount of avoided collection costs.

Under the arrangement, patients and their representatives would learn about the discount only during the course of the actual billing process. For example, the organization would inform patients of the discount offer when the patient registered for services or when the organization sent written account statements to the patient.

The OIG concluded that, together, these factors would reduce the risk that the proposed arrangement could be used as a means to attract patient referrals. And the OIG noted that the prompt payment discount would be implemented for the legitimate purpose of improving the organization's bill collection.

THE FUTURE OF DISCOUNTS

As with all OIG advisory opinions, keep in mind that the opinion is limited to the facts of this particular arrangement. This opinion suggests that the OIG may not impose sanctions if a health care provider carefully designs a prompt pay discount program to avoid the risks. But if it's not properly structured, discounts and other waivers of beneficiary cost-sharing amounts could generate prohibited remuneration and improper beneficiary inducement.

Ready or not

CMS rolls out its RAC program

All health care providers strive for payment accuracy on a day-to-day basis, and many have comprehensive processes in place to monitor compliance with Medicare billing requirements. But, national implementation of the Centers for Medicare and Medicaid Services' (CMS's) recovery audit contractor (RAC) program will bring increased scrutiny. In light of the permanent RAC program, health care providers should review their compliance plans, specifically related to documentation, coding and billing accuracy.

KNOW THE RAC BASICS

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 directed the U.S. Department of Health and Human Services to establish a demonstration program to determine whether the use of independent auditors was a cost-effective means to identify improper Medicare payments — including both overpayments and underpayments — and then recover overpayments. According to CMS' Office of Financial Management, the RACs in the demonstration states collected a total of $980 million in overpayments from health care providers during the three-year demonstration, which ran from March 2005 to March 2008.

The Tax Relief and Health Care Act of 2006 created a permanent RAC program and required CMS to expand the program nationwide on or before Jan. 1, 2010. As part of the program, by the summer of 2008, CMS should have commenced the first phase of its national expansion of permanent RACs. According to CMS, 22 states are scheduled for RAC program audits by the end of 2008. The remaining 28 states are scheduled for January 2009 or later.

EDUCATE YOUR STAFF

Whether or not your state is already participating in the permanent RAC program, you should educate your organization about it. If it has already been implemented in your state, it's not too late to provide your workers with a general understanding of the program and its review process, including the provider's obligations and rights during a RAC review.

Also educate your hospital leadership, physicians and direct care staff about your organization's compliance programs. For example, direct care staff should understand and adhere to patient care documentation requirements. This includes all of your coding, billing and payment rules. RAC reviews can include incorrect payment amounts, payments for noncovered services, incorrectly coded services and duplicate services. If the RAC requests medical records and you fail to provide them within 45 days, the claim could be considered, by default, an overpayment.

Include an overview of the appeals process. Health care organizations have the right to appeal RAC findings. Medicare provides five levels in the appeals process, starting with a redetermination by a fiscal intermediary, carrier or Medicare administrative contractor and culminating with judicial review in a U.S. District Court. Importantly, the appeals process ceases Medicare collection efforts for any alleged overpayment until a resolution is determined.

KEEP YOUR COMPLIANCE PROGRAM UPDATED

Many health care organizations have sophisticated compliance programs to support ongoing compliance with documentation, coding and billing. Be sure to consistently update your program with current Medicare regulations. Carefully review — either through an internal or external audit — those areas requiring further attention.

Review and analyze current publications on the CMS Web site (www.cms.hhs.gov/RAC) containing outcomes from RAC reviews to identify problematic areas. The Web site lists the top services with RAC-initiated overpayment collections in fiscal year 2007. Problematic areas of similar providers may also be problematic for you and possible target areas during a RAC review.

TAKE CORRECTIVE ACTION WHEN NEEDED

Whether compliance issues are found during internal compliance reviews or current RAC reviews, you should develop a detailed action plan addressing each area identified. For example:

- Address performance of your organization's RAC program team, including representation from health information management, compliance, finance, medical, case management, business office, ancillary and nursing staff.

- Improve direct care staff and physician documentation so that it's properly coded.
- Include education and training for coding staff and diagnostic related group (DRG) validation and benchmarking.
- Assess your health information management system to ensure effective and compliant medical records request processes (either during or in preparation for RAC reviews).

Finally, review patient billing protocols and validation of patient charges.

THE TIME IS NOW

Whether your organization is located in a state currently under RAC reviews or you're anticipating future RAC reviews, it's a good time to enhance your familiarity with the RAC process. Review your compliance plan, and, if necessary, implement applicable changes to documentation, coding and billing accuracy processes.

Not so fast …

The current nationwide implementation of the recovery audit contractor (RAC) program could be curtailed by House Bill 4105, the Medicare Recovery Audit Contractor Program Moratorium Act of 2007. This bill was introduced late last year and, as proposed, would impose a one-year moratorium on the use of RACs.

The bill is a response to health care providers' experience in the demonstration states. The bill's sponsors, Rep. Lois Capps and Rep. Devin Nunes (both of California), argue that the RAC program lacks oversight and has no consistent processes and procedures. They also cite the contingency fee payments to RAC contractors and the overall administrative burden that diverts resources away from patient care as reasons to support the moratorium. The American Hospital Association also wants improved program transparency and oversight before rolling out the RAC program.

In addition to placing a one-year moratorium on the RAC program, the legislation would require CMS and the Government Accountability Office to evaluate the RAC program and report their findings to Congress.

New IRS regulations clarify "excess benefit transaction"

You've probably heard the term "excess benefit transaction" in your health care organization. Not only should you be aware of the term, but you should also be up-to-date on the latest IRS regulations concerning this type of transaction. In fact, the IRS released final regulations earlier this year which can impact governing boards of nonprofit, tax-exempt hospitals.

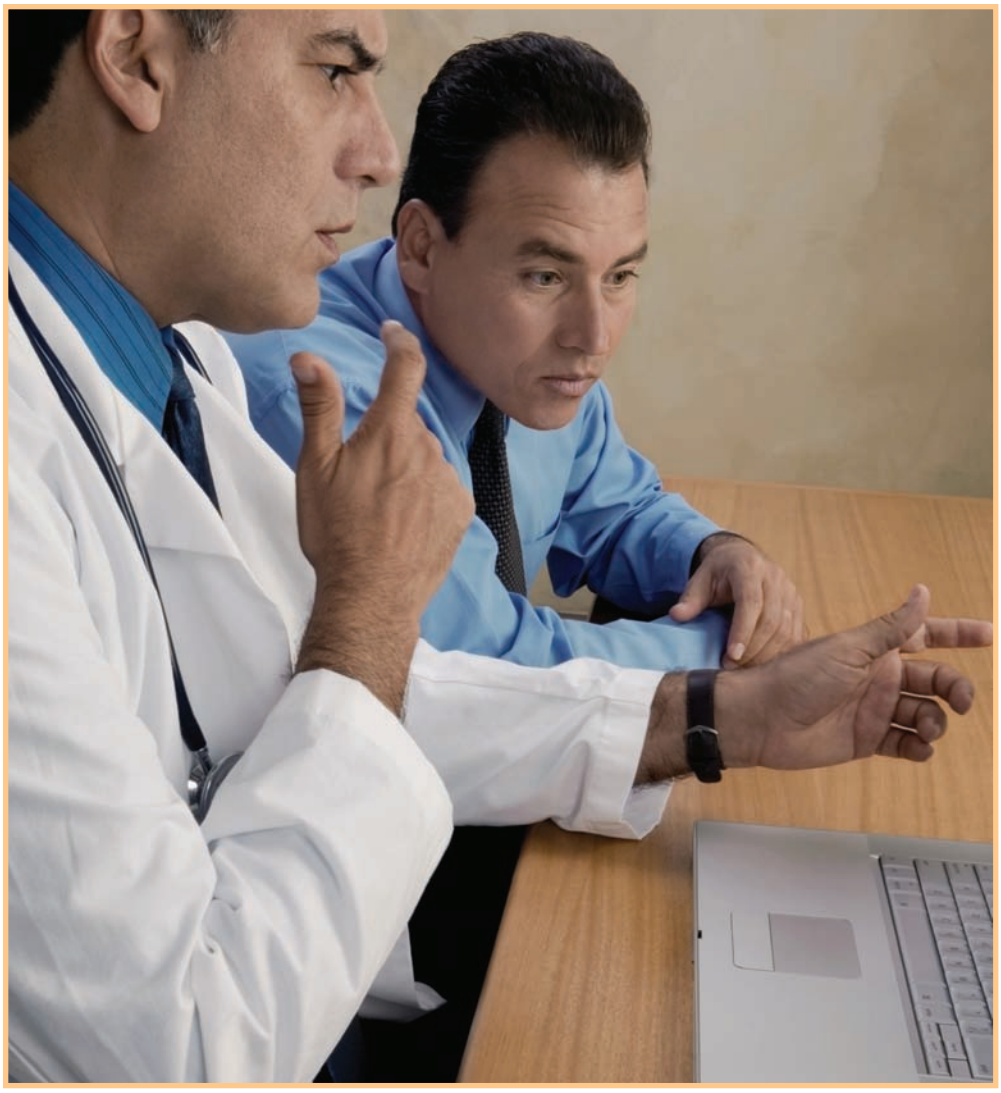
WHAT IS IT?

An excess benefit transaction is one in which an economic benefit is provided by an applicable tax-exempt organization, directly or indirectly, to or for the use of a disqualified person. The value of the benefit received by the disqualified person is measured against the fair market value of the item, goods, services or compensation.

For example, a tax-exempt hospital pays its top executive (a disqualified person) $500,000 in salary. But other top hospital executives in the geographic area are generally paid $350,000. If fair market value compensation for this position is $350,000, compensation in excess of that amount may be considered excessive compensation to the top executive, resulting in an excess benefit transaction.

The final regulations provide guidance on what the IRS will consider in determining whether an organization jeopardizes its tax-exempt status by engaging in an excess benefit transaction. Five factors the IRS analyzes include:

1. The organization's involvement in regular and ongoing exempt activities both before and after the excess benefit transaction occurred,
2. The relationship between the size and scope of the excess benefit transaction and the organization's regular exempt activities,



3. Whether the organization has a history of engaging in repeated excess benefit transactions,
4. Whether the organization has adopted compliance measures intended to prevent the occurrence of future intermediate sanctions violations, and
5. Whether the organization has corrected the excess benefit transaction or made a good faith effort to seek correction.

According to the regulations, the last two factors have greater weight in favor of maintaining an organization's tax-exempt status if the organization itself discovers the excess benefit transaction and takes corrective action *before* the IRS discovers the transaction.

DOES IT AFFECT COMPENSATION?

For tax-exempt health care organizations, one potential excess benefit transaction is paying unreasonable compensation to the hospital's top executives. The regulations provide examples of how the above factors are applied to a hypothetical tax-exempt organization setting its top executive's compensation. In one example, the board of directors' conduct placed the organization at risk for revocation of its tax-exempt status.

In the example, the board had adopted written procedures for setting executive compensation. It had appointed an independent compensation committee to gather data on compensation levels paid by similar organizations for functionally comparable positions. Then, based on the research presented, the board approved a new compensation arrangement for the CEO.

A subsequent IRS examination, however, found that the entities used in the comparison by the independent compensation committee weren't similar because they served substantially larger geographic regions and were larger than the organization in terms of annual revenues, total operating budget, number of employees and number of beneficiaries served. So the IRS concluded that the compensation committee hadn't relied on appropriate comparability data and had failed to establish the rebuttable presumption of reasonableness. Thus, the compensation package was excessive and constituted an excess benefit transaction.

But the IRS didn't revoke the organization's tax-exempt status based on the board's conduct. In making this determination, the IRS considered the five factors in the regulation. It found that the organization had engaged in regular and ongoing activities that furthered the exempt purposes both before and after the excess benefit transaction occurred.

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The IRS also concluded that the size and scope of the excess benefit transaction weren't significant in relation to the size and scope of the organization's activities that

furthered its exempt purposes. And despite the fact that the organization engaged in multiple excess benefit transactions, it had implemented written procedures for setting executive compensation. These procedures were reasonably calculated to prevent an excess benefit transaction, and the organization followed the written procedures in setting the compensation.

Notwithstanding the board's failure to rely on appropriate comparability data, its actions favored continued exemption because it had previously implemented and followed its written procedures in setting compensation. After an IRS examination determined an excess benefit transaction had occurred, the board's prompt action to amend its written procedures to ensure use of appropriate comparability data and subsequent renegotiation of the compensation package going forward were additional factors favoring continuation of the organization's tax-exempt status.

WHAT DO YOU NEED TO KNOW?

You can learn from the IRS example in the final regulation. Nonprofit hospital boards should focus on the use of appropriate industry comparables and make good faith efforts to immediately remedy excess benefit transactions before IRS intervention. Additionally, you should complete periodic evaluations of board processes related to compensation analysis. ❙

WAITING IN THE WINGS: RHIOs SEEK TAX-EXEMPT STATUS

The Department of Health and Human Services is determined to create a uniform system for health care information that can follow consumers throughout their lives. Regional health information organizations (RHIOs) are organizations (or groups of organizations) with a business stake in creating the infrastructure of this electronic health information. But can RHIOs qualify for exemption from federal income taxation as nonprofit organizations under Internal Revenue Code (IRC) Section 501(c)(3)?

To qualify, a RHIO must be organized and operated exclusively for charitable purposes and it can't provide improper benefits to third parties, including, but not limited to, its "insiders." Generally, IRC Sec. 501(c)(3) emphasizes activities that provide a public benefit. Therefore, a RHIO must demonstrate that it promotes the interests of the general public more than it promotes the interests of its stakeholders. For example, sharing health information among patients, physicians and other appropriate health care entities may be considered to provide a public benefit.

If a RHIO meets these and other applicable requirements for tax-exempt status, it will realize more than just tax advantages, including enhanced funding opportunities from private, governmental and charitable sources. Since 2005, several RHIOs have submitted applications to the IRS seeking tax-exempt status. However, the IRS hasn't ruled on the applications. Many RHIOs are seeking alternative financing despite pending applications with the IRS, while others have collapsed due to lack of funding.

The IRS is proceeding cautiously in reviewing the proper tax treatment of RHIOs. According to Steven Grodnitzky of the IRS, the decision had been delayed because RHIOs are a new type of business entity and aren't covered by statute or defined by legal principles found in case law.

Once the IRS begins issuing determination letters regarding pending applications as well as further guidance, it may be clear that certain RHIO activities are considered charitable and eligible for federal income tax exemption while other activities aren't charitable. With future guidance, each RHIO may better assess its corporate structure, proposed activities and funding opportunities for starting up and remaining financially viable.

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 would like to see addressed.

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