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HEALTH LAW: 2007 HIGHLIGHTS AND REMINDERS FOR 2008

This Health Care Alert highlights changes in health law compliance and legal requirements that became effective in 2007 or will become effective in 2008. The Alert identifies opportunities for hospitals, physicians and other health care providers to secure additional reimbursement on certain claims. We present reminders of requirements that will involve changes to policies, procedures and bylaws, or initiation of new audit and monitoring activities.

TEXAS MARGIN TAX

The Texas Comptroller announced final rules for the new Texas franchise tax, effective January 1, 2008. The new franchise tax (sometimes referred to as the “margin tax”) involves changes to the types of entities subject to tax, the tax base, and the tax rate for revenues. The new tax affects partnerships, corporations, limited liability companies, trusts, professional associations, business associations, joint ventures and most other types of business entities. A copy of the new rules is posted on the Comptroller’s website at http://www.window.state.tx.us/taxinfo/franchise/ft_revised.html.

Margin Tax Calculation

Each taxable entity generally must pay tax on its “taxable margin,” which is the lesser of three calculations: (1) total revenue minus cost of goods sold; (2) total revenue minus compensation; or (3) total revenue times 70%. Discounts in tax liability ranging from 20% - 80% are available for taxable entities with less than \$900,000 in total revenue. The tax rate is 1% for most entities and 0.5% for qualifying wholesalers and retailers. A taxable entity will owe no tax if its tax due is less than \$1,000, or its total revenue is less than or equal to \$300,000. Taxpayers with \$10 million or less in total revenue may elect to use an “E-Z Computation” to calculate their tax liability where a 0.575% tax is imposed on the entity’s total revenue, but without taking any deductions, credits, or making any other adjustments (other than the 20%-80% discounts described above).

Nontaxable Entities

Nontaxable entities include sole proprietorships, general partnerships (where direct ownership is solely by natural persons and the liability of those persons is not limited under any statute), passive entities, certain grantor trusts, estates of natural persons, escrows, certain REITs, REMICs, non-profit self-insurance trusts, IRC § 401(a) trusts and trusts exempt under IRC § 501(c)(9). A single member limited liability company treated as a sole proprietorship for federal tax purposes is not a sole proprietorship for Texas franchise tax purposes if formed in a manner to limit the liability of its owner/member.

Exemptions

An entity that has not previously established an exemption from the franchise tax with the Comptroller must apply for an exemption. Insurance companies that are subject to the annual gross premiums tax, public interest entities for counties, municipalities and other areas of Texas, and certain nonprofit entities are exempt from the franchise tax.

Revenue Exclusions for Health Care Providers

Health care providers exclude from total revenue the total amount of payments received (other than co-payments and deductibles received from the patient): (1) under Medicaid, Medicare, Indigent Health Care and Treatment Act and the Children's Health Insurance Program (including any managed care plans under these programs); (2) for professional services relating to a workers' compensation claim; (3) for professional services provided to TRICARE beneficiaries; and (4) from a third party agent or administrator for revenue earned under (1) – (3) above. The actual costs of uncompensated care (regardless of whether it was included in the total revenue calculation) are also excluded but only if the provider maintains records for auditing purposes and adjusts for payments received for all or part of such uncompensated care in the tax year in which the payment is received. Health care institutions (*e.g.*, hospitals, ASCs, nursing homes, home health agencies, etc.) exclude 50% of the exclusions for health care providers while physician entities exclude 100%. "*Actual costs of uncompensated care*" means either: (1) uncompensated care divided by total charges multiplied by operating expenses (provided if this method is used, a corresponding adjustment must be made in determining compensation by the ratio of uncompensated care to total charges); or (2) uncompensated care divided by total charges multiplied by the result of total operating expenses less compensation. "*Uncompensated care*" are accounts where the provider has received no payment.

The rules also address, among other things, calculation of total revenue, costs of goods sold and compensation, combined reporting, apportionment and franchise tax credits. For assistance on margin tax issues and calculation, please contact Kenneth Bozozo kenneth.bezozo@haynesboone.com.

MANAGED CARE SETTLEMENTS

Blue Cross Blue Shield of Texas (BCBSTX), United Healthcare of Texas and United Healthcare Insurance Company were part of 2007 settlements with physician organizations addressing managed care business practices. BCBSTX agreed to pay electronically-submitted claims within 15 business days and 30 days for paper claims and agreed to business practices changes similar to previous settlements between physician organizations and Aetna, CIGNA and Humana. United Healthcare companies agreed to certain benchmarks for claims payment accuracy and timeliness and handling of appeals and complaints. Aetna's settlement agreement has been extended to June 2, 2008 while CIGNA's settlement agreement expired September 4, 2007.

The Texas Department of Insurance reported that both Aetna and United Healthcare failed to meet performance standards for adjudication of clean claims within thirty days in the 2nd and 3rd quarters of 2007 and were fined.

For assistance in negotiating managed care contracts and incorporating terms from expired settlement agreements, please contact Lew Lefko lew.lefko@haynesboone.com. For assistance in collection of denied payments, underpayments, prompt pay and underpayment penalties and challenges to refund demands, medical necessity determinations and other managed care disputes, please contact Michael Hood michael.hood@haynesboone.com.

STARK II, PHASE III FINAL RULES

The Stark II, Phase III Final Rules, published September 5, 2007, were effective December 4, 2007. The rules affect various physician financial relationships with providers of designated health services (“DHS”). The following types of arrangements may need review and restructuring:

Compensation Arrangements

Individual physicians, whether members, employees or contractors, are deemed to “stand in the shoes” of their physician organizations and have the same financial arrangements with DHS entities as their contracting physician practice. A physician is now deemed to have a direct compensation arrangement with a DHS entity if the only intervening entity between the physician and the DHS entity is a physician organization. This rule change converts many indirect compensation arrangements into direct compensation arrangements for individual physicians. Consequently, application of the Stark exceptions for direct compensation arrangements, e.g., leases, personal services, isolated transactions, physician recruitment and others, must now be analyzed as if these individual physicians were the contracting entity. Arrangements that fit the indirect compensation exception on September 5, 2007 are “grandfathered” until the current term of their arrangement expires. At that time, those arrangements must comply with the detailed requirements of direct compensation arrangement exceptions.

Arrangements involving any intervening entity other than a physician organization, such as a management company or joint venture, or multiple intervening entities, will continue to require analysis under the indirect compensation arrangement and the indirect compensation arrangement exception.

However, CMS stated that arrangements structured so referring physicians own leasing, staffing and similar entities that furnish items and services to DHS entities which do not submit claims, raise significant fraud and abuse concerns and appear contrary to the intent of the Stark Law. The specific concerns involve physician-owners’ referrals to the contracting DHS entities which increase the physician-owned entity’s profits and investor returns, creating incentives for overutilization and corrupting decision-making.

Hourly-Based Compensation Arrangements

The safe harbor for determining fair market value (“FMV”) hourly compensation for physicians was eliminated. Parties may calculate FMV compensation using any commercially reasonable method that is appropriate under the circumstances of the arrangement and fits the FMV definition. The appropriate method for determining FMV depends on the nature of the transaction, its location, and other factors. FMV payment for administrative services performed by a physician may differ from FMV payment for clinical services furnished. Using an opportunity cost approach (time the physician loses to treating patients) for FMV determination of compensation for administrative services risks a Stark violation.

Physician Recruitment Agreements

More flexibility in the physician recruitment exception was promulgated for the geographic area test, practice restrictions, income guarantees and rural area recruiting. Noncompete covenants must not be unreasonable or have a substantive effect on the recruited physician's ability to remain in the hospital's geographic service area.

Equipment/Space Leases And Personal Services Contracts

Guidance was provided that rental charges and payments for personal services may not be amended at any time during the term of a lease or contract. Parties must terminate the lease or contract and enter into a new agreement if the rent or payments will be changed. Similarly, changes to material terms of the lease or contract, e.g., an expansion of the space leased or an increase in the scope of the services, may not be changed if doing so would cause the rental or payment rate to be inconsistent with FMV or relate to the volume or value of referrals. The usual method of amending the lease or contract will violate the "set in advance" criterion for compensation arrangements if such changes occur.

A lessee must have exclusive use of the leased equipment or space and may not share it with the lessor (or a related individual or entity) during any period of time the lessee has use of the property, i.e., shared lease arrangements must be structured using "block-time" provisions.

Many other rules were changed and the preamble to the rules adds clarification and guidance regarding Stark definitions and exceptions. For assistance with revising policies and procedures and restructuring compensation arrangements and joint ventures to comply with the Stark II, Phase III rules, please contact Jeff King jeff.king@haynesboone.com or Lew Lefko lew.lefko@haynesboone.com.

LTCH CHANGES

Congress passed and President Bush is expected to sign, the Medicare, Medicaid and SCHIP Extension Act of 2007. In addition to eliminating the scheduled 10.1% cut to Medicare physician reimbursements in 2008 and extending the State Children's Health Insurance Program funding through March 31, 2009, the legislation:

- Imposes a limited moratorium on the development of new Long Term Acute Care Hospitals ("LTCHs") and on increases in the number of beds by existing LTCHs;
- Provides reimbursement relief by postponing the application of the 25% patient threshold payment adjustment for three years for freestanding LTCHs, and revising the payment adjustment to not apply if no more than 50% of the LTCH's Medicare discharges are admitted from the co-located acute care hospital in a hospital-within-a hospital arrangement;
- Expanded the review of the medical necessity of admissions and continued stays in LTCHs; and
- Requires a study on LTCH admission, continued stay and discharge criteria.

FINAL 2008 FORM 990 FOR TAX-EXEMPT ORGANIZATIONS

On December 20, 2007, the Internal Revenue Service issued a final Form 990 for use by tax-exempt organizations (“EOs”) for the 2008 tax year. For the hospital and tax-exempt bond schedules, the IRS announced a phase-in with certain identifying information required for the 2008 tax year and completion of the entire schedules for the 2009 tax year.

The core form has a governance section with questions about the governing body and its management, policies and public disclosure of Form 990, governing documents, conflict of interest policies and financial statements.

Schedule H for hospitals requires a listing of all hospitals and other medical facilities operated by the EO. Affiliated hospital systems will report on an entity-by-entity basis. For community benefit reporting beginning in 2009, bad debt expense and Medicare shortfalls are not included in charity care. Bad debt, Medicare shortfalls and collection practices will be reported in a separate section. Hospitals are required to provide an estimate of how much of bad debt and Medicare shortfalls are attributable to persons who qualify for financial assistance under their charity care policies and a rationale for what portion of bad debt and Medicare shortfalls should constitute community benefit.

The IRS plans to release the related instructions for Form 990 in early 2008.

If you have questions or need assistance in preparing the new Form 990 and its schedules, please contact Jeff King jeff.king@haynesboone.com or Lew Lefko lew.lefko@haynesboone.com regarding governance and community benefit issues and Kenneth Bezozo kenneth.bezozo@haynesboone.com or John Collins john.collins@haynesboone.com for other Form 990 and EO reporting requirements.

PENALTIES AND TIME PERIODS FOR UNDERPAID HMO AND PPO CLAIMS

The Texas Department of Insurance issued proposed rules to implement SB 1884, enacted by the 80th Legislature and effective September 1, 2007. The rules amend the formula for determining penalty amounts for certain underpaid claims and the timeframes affecting an HMO or PPO’s liability for underpaid claim penalties:

- The underpaid claim penalty formula is calculated on the ratio of the amount underpaid on the contracted rate to the contracted rate as applied to an amount equal to the billed charges as submitted on the claim minus the contracted rate; and
- An HMO or PPO is not liable for underpaid claim penalties if the claim is paid in accordance with the submission of clean claims rules, the provider sends notice of the underpayment after the 270th day after the date the underpayment was received, and the HMO or PPO pays the balance of the claim on or before the 30th day after receiving the provider’s notice.

USE OF FORMULARIES IN HOSPITALS

The Texas State Board of Pharmacy proposed rules on November 23, 2007 to allow a physician to grant approval for pharmacists at a hospital to substitute, in accordance with the hospital's formulary, for the prescribed drugs on the physician's medication orders if:

- the pharmacy and therapeutics committee has developed a formulary that has been approved by the medical staff executive committee;
- there is a reasonable method for the physician to override any substitution; and
- the physician authorizes hospital pharmacists to substitute on the physician's medication orders in accordance with the hospital's formulary through the physician's written agreement to the hospital's policies and procedures.

ADDITIONAL MEDICARE REIMBURSEMENT OPPORTUNITIES

Hospitals, ACSs, imaging facilities, HHAs and physicians may be eligible for additional Medicare reimbursement for applicable items and services mentioned below. Medicare will not search their files to retroactively pay claims, but will adjust claims that are brought to their attention. Check the Medicare website <http://www.cms.hhs.gov/> for additional information.

- Effective January 1, 2007, separate payment is made for the contrast media used in various magnetic resonance imaging ("**MRI**") procedures. The cost of the contrast media is no longer included in the practice expense relative value units for the MRI procedures.
- Effective on and after May 22, 2007, payment is allowed for the monitoring of cardiac output (Esophageal Doppler) for ventilated patients in the ICU and for operative patients with a need for intra-operative fluid optimization. The previous non-coverage of cardiac output Doppler monitoring was removed.
- Hospitals and home health agencies are reminded of updated payment rates for selected drugs and biologicals that had incorrect payment rates in the January 2007 and April 2007 OPPS PRICER. The corrected rates were installed in the October 2007 OPPS PRICER.
- Hospitals and physicians may bill and be paid for ICD-9-CM diagnosis code 433.11, occlusion of the carotid artery with infarct, under the list of payable claims for Percutaneous Transluminal Angioplasty, effective March 17, 2005. Due to an administrative error, Medicare is allowing acceptance of claims outside the timely filing limits.

JOINT COMMISSION STANDARDS

The Joint Commission has issued new standards that will require changes to healthcare providers' bylaws, policies and procedures. The Joint Commission adopted a revised Leadership chapter effective January 1, 2009. The Leadership chapter addresses leadership structure and relationships, organization culture and system performance, and operations.

The Joint Commission revised Hospital Accreditation Standard Medical Staff 1.20 effective July 1, 2009. The revisions address medical staff bylaws and rules and regulations and the placement of processes and procedural details of medical staff functions in those documents. The revisions narrow the authority of the medical executive committee ("**MEC**") to adopt such processes and procedural details. The revisions also address the delegation of authority to the MEC, roles and responsibilities of medical staff categories, and requirements for performing medical histories and physical examinations.

Please contact Lew Lefko lew.lefko@haynesboone.com for assistance in revising governing documents and policies affected by the new Joint Commission Standards.

MEDICARE ANTI-MARKUP RULE FOR DIAGNOSTIC TESTS

On December 28, 2007, CMS issued a final rule delaying until January 1, 2009 the applicability of the anti-markup rule for diagnostic tests, as revised at 72 FR 66222 on November 27, 2007, except with respect to the technical component (TC) of a purchased diagnostic test and any anatomic pathology diagnostic testing services furnished in space that is (i) utilized by a physician group practice as a "*centralized building*" (as defined at 42 CFR 411.351) for purposes of complying with the physician self-referral rules, and (ii) does not qualify as a "*same building*" under 42 CFR 411.355(b)(2)(i).

The delayed effect of the rule is due to confusion over the definition of the "*office of the billing physician or other supplier*". CMS received comments that patient access may be significantly disrupted if medical office space that satisfies the "*same building*" test and other medical office space in which patients are seen and that complies with the physician self-referral rules are subject to the anti-markup provisions. Physician groups alleged that if they were subject to anti-markup and limited to billing Medicare for net charges imposed by the performing supplier, and not able to realize a profit and recoup their overhead costs, they would be unable to continue providing diagnostic services to the same extent.

To prevent unintended consequences, anti-markup will apply on January 1, 2008 to anatomic pathology diagnostic testing services furnished by group practices under the "*centralized building*" test of the Stark rules for in-office ancillary services and that does not qualify as a "*same building*", e.g., "*pod labs*". In addition, CMS is not delaying applicability of the revised markup rule to the TC of any purchased diagnostic tests since the anti-markup prohibition on the TC of purchased diagnostic tests has been longstanding.

CMS indicated clarifying guidance, additional rulemaking or both, would be issued as to what constitutes “the office of the billing physician or other supplier”.

The anti-markup rule applies if a physician or other supplier bill for the technical component (“TC”) or professional component (“PC”) of a diagnostic test:

- Ordered by the physician or other supplier, or by a related party under common ownership or control; and
- Either purchased from an outside supplier or performed at a site other than the office of the billing physician or other supplier.

If applicable, anti-markup limits reimbursement to the lowest of: (1) the performing supplier’s net charge to the billing physician or supplier (without regard to any charge to the performing supplier by or through the billing physician or other supplier for the cost of equipment or leased space); (2) the billing physician’s or other supplier’s actual charge; or (3) the fee schedule amount for the test if the performing supplier billed Medicare directly.

Under Texas law, *Texas Occupations Code*, Chapter 166, a person, including a physician and an entity, is subject to disciplinary action and penalties if the person:

- Does not directly supervise or perform anatomic services for a patient; and
- Fails to disclose in the bill presented by the person to the patient, insurer or other third party payor, or in an itemized statement to the patient (i) the name and address of the physician or laboratory that provided the anatomic services, and (ii) the net amount paid or to be paid for each anatomic pathology service provided to the patient by the physician or laboratory.

Additionally, *Texas Health and Safety Code*, Chapter 161, Subchapter F, §161.061-.062, addresses the disclosure of certain agreements for payment of laboratory tests. A person licensed in Texas to practice medicine, dentistry, podiatry, veterinary medicine, or chiropractic may not agree with a clinical, bioanalytical, or hospital laboratory to make payments to the laboratory for individual tests, combinations of tests, or test series for a patient unless:

- The person discloses on the bill or statement to the patient or to a third party payor the name and address of the laboratory and the net amount paid to or to be paid to the laboratory; or
- Discloses in writing on request to the patient or third party payor the net amount. This type of disclosure must show the charge for the laboratory test or test series and may include an explanation, in net dollar amounts or percentages, of the charge from the laboratory, the charge for handling, and an interpretation charge.

WORKPLACE E-MAIL POLICIES

The National Labor Relations Board decided *The Guard Publishing Company* case on December 16, 2007 ruling employers will not commit an unfair labor practice by instituting policies stating the employer's e-mail systems may not be used to solicit or proselytize for commercial ventures, religious or political causes, outside organizations or other non-job related solicitations. The ruling concluded, absent discrimination, employees have no statutory right to use an employer's equipment or media for union-related communications. However, a communications policy must not discriminate between activities or communications of a similar character because of their content or protected status.

If you need any assistance on how to revise and implement workplace communications policies under the NLRB's new rule, please contact Felicity Fowler felicity.fowler@haynesboone.com or Michael McCabe michael.mccabe@haynesboone.com.

HIPAA

PriceWaterhouseCoopers will be conducting HIPAA security standards audits for the federal government in 2008. The targets of the audits will be health care providers and health plans which have security complaints filed against them. According to CMS information, the most common security complaints involve information access management, security awareness and training, access control, workstation use, and device and media controls.

Security standards assistance for sole practitioners and small health care providers was offered by CMS in its *HIPAA Security Series, #7*, published on December 10, 2007. Sample questions are provided for evaluation and/or establishing security practices.

CMS issued a revision to its *CMS Policy for the Information Security Program* on November 15, 2007. The policy sets the rules for how CMS operates and safeguards its information systems to reduce the risk and minimize the effect of security incidents.

Readers of this Alert may wish to re-read *HIPAA Security Compliance: Recent Developments* published on March 21, 2007, for additional information on security standards audits.

If you would like advice on the matters mentioned in Health Law: 2007 Highlights And Reminders For 2008, or more information, please contact one of the Haynes and Boone Health Care Practice Group or Business & Tax Planning attorneys listed on the following page.

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