SUPREME COURT AND IRS ADDRESS MEDICAL RESIDENT FICA TAXATION

The payment of FICA taxes (social security and Medicare taxes) on stipends provided to medical residents by teaching hospitals has long been an area of debate, with the IRS taking the position that the stipends are "wages" paid for "services" and requiring the residents and the hospitals to pay FICA taxes totaling more than 15 percent of the amount of the stipend. Over the past five years, Baker Hostetler has represented teaching hospitals in challenging that position. Within the past month, both the IRS and the U.S. Supreme Court have made important pronouncements that are helpful to teaching hospitals caught in these disputes.

IRS Concession of Pre-2005 Disputes

Earlier this year, the IRS announced that it would concede medical resident cases for quarters prior to and including the first quarter of 2005 -- the effective date of Treas. Reg. 31.3121(b)(10)-2 which attempted to bar medical resident FICA refund claims for periods beginning on and after April 1, 2005. Just prior to Memorial Day, the IRS issued long-awaited guidance on the procedures it will employ in processing those concessions. The IRS guidance focuses on procedural requirements that taxpayers must satisfy in order to obtain a refund under the government's announced substantive concession and consists of roughly 40 pages of standardized forms and instructions. Under this guidance, teaching hospitals will be required to determine the amount of FICA taxes applicable to each resident for each quarter, and will need to obtain the written consent of the residents as preconditions to any recovery of the FICA taxes. These procedural requirements will impose very substantial requirements of both time and other resources upon tax professionals at medical institutions. Baker Hostetler urged the IRS during the development of these procedures to reduce this burden.

Supreme Court Action for Post-Regulation Periods

Following promulgation of Treas. Reg. 31.3121(b)(10)-2 in 2005, the IRS took the position that medical institutions and former residents could not obtain FICA refunds for periods after March 31, 2005. Some taxpayers challenged the validity of the regulation, contending that the IRS did not have the regulatory authority to deprive taxpayers of FICA refunds they could otherwise obtain under the statutory language. Nonetheless, the validity of the regulation was upheld by the Eighth Circuit Court of Appeals in Mayo Foundation for Medical Education & Research v. United States, 568 F.3d 675 (8th Cir. 2009).

On June 1, 2010, the Supreme Court agreed to hear the Mayo Foundation case. Should the Mayo Foundation succeed before the Supreme Court, other teaching hospitals would have a largely unobstructed path toward recovering FICA taxes for post-regulation years. A decision on the merits by the Court is probably at least a year away. In the interim, teaching hospitals will want to reexamine their treatment of FICA liabilities for the post-regulation years to ensure that their rights are preserved in the event the regulation is invalidated.
We have assisted clients in processing both pre-2005 and post-2005 claims. For more information, please contact Tom Kahle, tkahle@bakerlaw.com or 513.929.3414 or Stu Bassin, sbassin@bakerlaw.com or 202.861.1736.

PASSING OFFENSE BY SUPREME COURT HITS HEALTHCARE PROVIDER POST-REFORM COLLABORATION

Healthcare joint ventures formed by competing providers are likely to come under increased scrutiny following a rare unanimous decision by the U.S. Supreme Court on May 24, 2010. In American Needle v. National Football League, the Court held that collaborators are not categorically immune from antitrust scrutiny under the Sherman Act § 1, if they engage in a collective action that deprives the marketplace of independent competitors.

The Supreme Court reaffirmed that joint ventures will not be insulated from antitrust liability for "concerted action" among separate economic decisionmakers with separate interests who represent actual or potential competition. In determining whether concerted action exists, the Sherman Act looks beyond the form of a collaboration, such as whether the parties are legally distinct entities, in favor of examining how the collaborators actually operate. In the NFL case, for example, the Court held that the National Football League Properties (NFLP), formed to license NFL merchandise by a group of 32 competing teams, was not a single entity as it was controlled by a group of competitors who were pursuing their own separate economic interests. On the other hand, if multiple entities that are "separate" for purposes of incorporation or formal title, "are controlled by a single center of decisionmaking and they control a single aggregation of economic power," an agreement between them will not constitute concerted action. The Court, however, did not address whether a joint venture that completely terminates competition among its members will be treated, for that reason alone, as a single entity. "Concerted" conduct is subject to the more stringent standards of the Sherman Act § 1, whereas "unilateral" conduct is subject only to the monopolization provisions of the Sherman Act § 2.

According to the Court, NFL teams "do not possess either the unitary decisionmaking quality or the single aggregation of economic power characteristic of independent action. Each of the teams is a substantial, independently owned, and independently managed business. '[T]heir general corporate actions are guided or determined' by 'separate corporate consciousnesses,' and '[t]heir objectives are' not 'common.'" Consequently, the NFL is subject to the more stringent standards of the Sherman Act § 1.

If a joint venture arrangement is controlled by a group of competitors, the legality of the collaboration will be reviewed under "rule of reason" analysis when restraints on competition are essential if the product is to be available at all. The rule of reason standard evaluates whether an activity is an unreasonable restraint of trade by balancing the negative effects of the collaboration on competition against business, economic and consumer benefits.

The NFL decision also highlighted that different facets of a collaboration may be evaluated separately to determine whether an antitrust violation exists. The Court rejected the NFL’s argument that the teams should be treated as a single entity simply because joint action was necessary to produce NFL football. Just because parties enter into a joint venture for a particular purpose, it does not mean that the collaborators will be insulated from antitrust liability in regard to all things they may do together.

Simply forming a joint venture or arrangement will not preclude a finding of concerted action under antitrust law, regardless of whether the joint venture claims to represent a form of clinical integration, or one of the new types of bundled payment/integrated care entities under the Patient Protection and Affordable Care Act (PPACA), such as...
accountable care organizations. Careful evaluation of the interrelationships of the venture's participants and the impact of the collaboration on the marketplace must be undertaken.

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CMS SHARES THOUGHTS ON ACOs AND SHARED SAVINGS PROGRAMS

PPACA established several demonstration programs to test and evaluate new Medicare healthcare delivery and payment models. This effort is designed to not only improve care coordination and quality, but also to reduce the rate of healthcare spending growth. These demonstration projects, which are part of the Shared Savings section of PPACA, include bundled payments, accountable care organizations (ACOs) and the patient-centered medical home. In addition to the delivery models specifically identified, PPACA also established a new Center for Medicare and Medicaid Innovation within the Centers for Medicare & Medicaid Services (CMS) that can test other care models -- giving the U.S. Department of Health and Human Services (HHS) the authority to expand the scope and duration of the new models, including the authority to implement them nationwide.

An ACO is an organization of healthcare providers that agrees to be accountable for the quality, cost and overall care of Medicare beneficiaries enrolled in the traditional fee-for-service program who are assigned to it. CMS recently issued a Q&A addressing ACOs. The Q&A generally reiterates PPACA with respect to how an organization can qualify as an ACO. However, the Q&A also clarifies several points not addressed in the statute. These include:

- Medicare beneficiaries will not have access reduced by ACOs. CMS stated that for purposes of an ACO “assigned” means those beneficiaries for whom the professionals in the ACO provide the bulk of primary care services and that it will not affect their guaranteed benefits or choice of doctor.
- Regulations will be proposed in the fall.
- ACOs meeting specified quality performance standards will be eligible to receive a share of the savings if the actual per capita expenditures of their assigned Medicare beneficiaries are a sufficient percentage below their specified benchmark amount. The benchmark for each ACO will be based on the most recent available three years of per-beneficiary expenditures for Parts A and B services for Medicare fee-for-service beneficiaries assigned to the ACO. The benchmark for each ACO will be adjusted for beneficiary characteristics and other factors determined appropriate by the Secretary of HHS and updated by the projected absolute amount of growth in national per capita expenditures for Part A and B.
- ACOs will not be penalized if quality targets are not achieved.

Baker Hostetler is currently working with several clients on the development of ACOs and on various integration strategies that may be used in developing an ACO in the future. Over the next several issues of the Health Law Update, we will take a closer look at each of the shared savings opportunities and how healthcare providers can be best positioned to maximize opportunities under the shared savings programs.

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CMS CLARIFIES PHYSICIAN SUPERVISION OF INCIDENT-TO SERVICES PROVIDED ON AN OUTPATIENT BASIS

On May 28, 2010, CMS clarified the physician supervision requirements for diagnostic and therapeutic services provided to hospital outpatients. Transmittal 128 provides further explanation regarding two elements of direct supervision that were inadequately addressed in the CY 2010 Outpatient Prospective Payment System (OPPS) Final Rule (OPPS Final Rule): (1) the concept of "immediately available," and (2) the credentials, knowledge, skills, ability and privileges that the supervisory practitioner must possess in order to be qualified to perform a given service or procedure. For more information on the OPPS Final Rule, please see the November 12, 2009, issue of the Health Law Update.

CMS defines "direct supervision" as requiring a physician to be: (1) "present on the premises of the location," and (2) "immediately available to furnish assistance and direction throughout the performance of the procedure." 42 C.F.R. § 410.27(f). In the OPPS Final Rule, CMS attempted to clarify the term "immediately available" but did not specifically define the word "immediate" in terms of time or distance. Rather, CMS noted that the general definition of the word means, much to the alarm of many commenters, "without interval of time." While Transmittal 128 does not use the term "without interval of time," it does not otherwise clarify the standard; CMS merely restates examples used in the OPPS Final Rule. CMS reiterates that "an example of a lack of immediate availability would be situations where the supervisory physician is performing another procedure or service that he or she could not interrupt" and "for services furnished on-campus, the
supervisory physician may not be so physically far away on-campus from the location where hospital outpatient services are being furnished that he or she could not intervene right away."

Another controversial issue was the OPPS Final Rule "clarification" that furnishing assistance and direction throughout the performance of the procedure means "the physician or nonphysician must be prepared to step in and perform the service, not just respond to an emergency." (emphasis added). Thus, the supervisory physician or nonphysician practitioner "must have, within his or her State scope of practice and hospital-granted privileges, the ability to perform the service or procedure." We found this particularly problematic for highly specialized fields, such as chemotherapy and radiation oncology, where physicians rely on team-member technicians to perform dedicated functions. However, in response to comments to the OPPS Final Rule which argued that this standard was too stringent, CMS dismissed such concerns, stating that ["i"]t would be unreasonable to think that a physician or nonphysician practitioner could competently assist and direct a procedure for which they do not have sufficient knowledge and skills to perform or redirect the procedure or service." Through Transmittal 128, it appears CMS now recognizes the reality that: Specially trained ancillary staff and technicians are the primary operators of some specialized diagnostic testing equipment, and while in such cases CMS does not expect the supervisory physician to operate this equipment instead of a technician, the physician that supervises the provision of the diagnostic service must be knowledgeable about the test and clinically appropriate to furnish the test. (emphasis added).

Thus, while the supervisory physician must still have, within his or her state scope of practice and hospital-granted privileges, the knowledge, skills, ability and privileges to perform the service or procedure, the Transmittal sums up the standard as "the supervisory physician must be clinically appropriate to supervise the service or procedure."

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FALSE CLAIMS ACT – IMPROPER LEVEL OF CARE NETS $9.5M SETTLEMENT

The U.S. Department of Justice recently announced the latest settlements in its fraud enforcement initiative relating to Medicare claims for "kyphoplasty," which involves a minimally-invasive procedure for spinal fractures often related to osteoporosis. The kyphoplasty enforcement initiative originated with a False Claims Act lawsuit against Kyphon Inc., which developed kyphoplasty and marketed a kit used in the procedure. The lawsuit was filed by two former Kyphon employees-turned-whistleblowers, a reimbursement manager and regional sales manager. In May 2008, Medtronic Spine LLC, corporate successor to Kyphon Inc., paid $75 million to settle allegations that the company defrauded Medicare by counseling hospital providers to perform kyphoplasty procedures as an inpatient procedure even though the minimally-invasive procedure should have been done as an outpatient procedure in many cases. In addition to Kyphon Inc., the whistleblowers also brought suit against a number of hospitals for kyphoplasties that allegedly were improper when billed as an inpatient procedure instead of an outpatient service. The latest settlements involve nine hospitals in Alabama, Florida, Indiana, Michigan, Minnesota, New York and South Carolina that agreed to pay a total of $9.4 million to settle false claims allegations related to the matter.

"It is critical that providers make patient admission decisions based on medical necessity and the level of care needed rather than on the Medicare payment they will receive," said Daniel R. Levinson, HHS Inspector General. "The Office of Inspector General will continue to pursue providers who abuse the Medicare Trust Fund and divert for personal gain resources that should be going to pay for necessary care."

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HIPAA HAS TEETH – PART II

Under the Health Information Technology for Economic and Clinical Health Act (HITECH Act), the federal government’s expanded HIPAA privacy and security enforcement powers are leading many covered entities and business associates to re-evaluate their HIPAA compliance programs and preparedness for responding to and mitigating HIPAA privacy or security violations. While in the past HIPAA violations could subject a covered entity to anywhere from $100 to $25,000 in penalties per violation, under HITECH, such penalties have been increased dramatically to as much as $50,000 per violation, with a $1.5 million cap. Furthermore, the government’s enforcement powers have been expanded to include compliance audits and the more robust pursuit of privacy and security complaints and investigations. In the event of a breach of unsecured protected health information (PHI), the HHS Office for Civil Rights (OCR) likely will become involved, either through a complaint filed by an individual, or by public reporting of a breach affecting the PHI of 500 or more individuals. One of the likely first areas of inquiry may be the status of your organization’s HIPAA privacy and security
policies and procedures and HIPAA training documentation. A specific area that may warrant increased focus in your organization may be compliance with the HIPAA Security Standards, which have been in effect and applicable to covered entities since 2005.

HITECH Act -- Draft HIPAA Guidance Documents

On May 7, 2010, OCR issued the first in a series of draft HIPAA guidance documents under the HITECH Act, discussing ways that covered entities should conduct a risk assessment, an important component of complying with the HIPAA Security Standards. The guidance is especially relevant today given that: (1) business associates are now subject to implementing HIPAA security safeguards, and (2) the Medicare and Medicaid financial incentives available to providers who implement "meaningful use" of electronic health records require compliance with HIPAA privacy and security standards. Specifically, a required component of the Stage 1 criteria that eligible professionals and hospitals must satisfy under the proposed rule for "meaningful use" [74 Fed. Reg. 1844, 1858-1867 (Jan. 13, 2010)] is to conduct a security risk analysis at least once prior to the end of each reporting period. HHS states, "[t]his is to ensure that the certified EHR technology is playing its role in the overall strategy of the [eligible professional] or eligible hospital in protecting health information." The risk analysis should be just one component of an organization-wide HIPAA risk management strategy, according to HHS.

The draft guidance issued by OCR addresses risk analysis in an eight-fold process:

1. Identifying sources and uses of PHI
2. Identifying threats and vulnerabilities
3. Assessing current security measures
4. Determining likelihood of threat occurrence
5. Determining the potential impact of a threat occurrence
6. Assigning risk levels to combinations of threats, vulnerabilities and impacts
7. Documenting the risk analysis
8. Periodically reviewing and updating the risk analysis

The draft guidance provides useful references to several sources of government, industry and public sector security guidance, including those published by the National Institute of Standards and Technology (NIST), the Healthcare Information and Management Systems Society (HIMSS), the Office of National Coordinator for Health Information Technology (ONC) and the Common Security Framework (CSF) of the Health Information Trust Alliance (HITRUST).

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EVENTS CALENDAR

June 11, 2010

Houston partner Susan Feigin Harris will speak on "Health Care Reform -- What's Next" at the State Bar of Texas Annual Meeting in Fort Worth, Texas.