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CMS ISSUES PROPOSED RULE ON THE REPORTING AND RETURN OF OVERPAYMENTS

On February 16, 2012, the Centers for Medicare & Medicaid Services (CMS) released a proposed rule regarding the obligations of providers and suppliers to report and return Medicare overpayments (Proposed Rule). CMS states that it will issue guidance regarding the overpayment obligations of other stakeholders, including Medicare Advantage Organizations, PDP Sponsors, and Medicaid Managed Care Organizations, at a later date. While the Proposed Rule is not binding and does not have the force of law, it does provide useful insight into the current views of CMS on this issue. Some key provisions of the Proposed Rule are as follows:

Implementation of Statutory Requirements

The Proposed Rule is intended to implement Section 1128J(d) of the Medicare Act (Act), which requires that an overpayment be reported and returned by the later of: (1) 60 days after the date on which the overpayment is identified; or (2) the date any corresponding cost report is due, if applicable. The Act provides that failure to report an overpayment within these time frames can result in liability under the False Claims Act (FCA).

Use of Existing Refund Process

CMS proposes to implement the report and refund obligation through the existing voluntary refund framework, which will be renamed the "Self-Reported Overpayment Refund Process." This process is described in Publication 100-06, Chapter 4 of the Medicare Financial Management Manual. CMS plans to develop a uniform reporting form to enable all

overpayments to be reported and returned in a consistent manner across all Medicare contractors. Until such form is made available, CMS instructs providers and suppliers to use the existing form available on the website of their applicable Medicare contractor.

Clarification Regarding When an Overpayment Is "Identified"

The Proposed Rule proposes that "a person has identified an overpayment if the person has actual knowledge of the existence of the overpayment or acts in reckless disregard or deliberate ignorance of the overpayment." CMS believes that this clarification will encourage reasonable diligence on the part of providers and suppliers who otherwise might avoid undertaking voluntary efforts to identify overpayments through compliance programs or self-audits.

Interplay with the Stark and OIG Self-Disclosure Protocols

The Proposed Rule addresses the intersection between the Medicare Act's report and return process and disclosures under the Medicare Self-Referral Disclosure Protocol (SRDP) and the OIG Self-Disclosure Protocol (OIG SDP).

CMS states that providers or suppliers who disclose Stark violations under the SRDP must also report any associated overpayments using the process outlined in the Proposed Rule. However, the Proposed Rule provides that the 60-day obligation to return such overpayments will be suspended upon CMS's receipt of a disclosure under the SRDP.

CMS states that disclosure of overpayments through the OIG SDP would satisfy the reporting obligation under the Proposed Rule, provided that such disclosures are made in accordance with the Proposed Rule's timeliness requirement. The Proposed Rule further proposes that the obligation to return such overpayments be suspended until a settlement agreement is entered or the provider/supplier withdraws or is removed from the OIG SDP.

Reporting of Anti-Kickback Violations

CMS notes that compliance with the Anti-Kickback Statute (AKS) is a condition of Medicare payment, and that paid claims arising out of transactions that violate the AKS are overpayments. CMS also recognizes, however, that in many instances a provider or supplier is not a party to, and may not be unaware of, the existence of an arrangement between third parties that causes the provider or supplier to submit claims that arose out of a kickback. Accordingly, CMS states that, absent extraordinary circumstances, providers and suppliers "who are not a party to a kickback arrangement are unlikely in most instances to have 'identified' the overpayment that has resulted from the kickback arrangement and would therefore have no duty to report it or . . . to repay it."

Civil Monetary Penalties and Exclusion

The Act provides that persons who knowingly retain overpayments beyond the applicable time frames can be held liable under the FCA. The Proposed Rule adds that such persons can also be found liable under the Civil Monetary Penalties Law and subject to exclusion from participation in federal health care programs.

Ten-Year Lookback

CMS proposes that overpayments must be reported and returned only if identified within 10 years of receipt. CMS states that the 10-year lookback period is based on the outer limit of the FCA statute of limitations. For purposes of consistency, CMS also proposes to amend the reopening rules to provide that overpayments reported in accordance with the Proposed Rule may be reopened for a period of 10 years.

Estimated Volume of Self-Reports

CMS estimates that 8.5 percent of all Medicare providers and suppliers (approximately 125,000) will report and return overpayments under the Proposed Rule on an annual basis. CMS anticipates that each such entity will report and return three to five overpayments.

The Proposed Rule is scheduled for publication on February 16, 2012. Comments on the Proposed Rule will likely be due by April 16, 2012. Robinson & Cole will continue to monitor the status of the Proposed Rule as it proceeds through the rulemaking process.

IRS REVISES FORM 990 FOR TAX-EXEMPT ORGANIZATIONS FOR 2011 TAX YEAR

On January 21, 2012, the Internal Revenue Service (IRS) published a revised Return of Organizations Exempt from Income Tax (Form 990) and accompanying instructions for tax-exempt organizations for tax year 2011. Schedule H, the Form 990 addendum for organizations that operate tax-exempt hospitals, and the accompanying instructions were also revised.

The Patient Protection and Affordable Care Act of 2010 (PPACA) amended sections of the Internal Revenue Code (Code) and required tax-exempt hospitals to adhere to new reporting standards. In early 2011, the IRS released a revised Form 990 and accompanying instructions to reflect those amendments. For a summary of those changes, see Health Law Pulse - March 2011.

The IRS has revised Form 990 and Schedule H to require tax-exempt organizations and hospitals to report additional metrics. Notable revisions to Form 990 include changes to joint venture, governance, and compensation reporting. Revisions to Schedule H include changes to the facility policies and practices requirements. These revisions are discussed in more detail below.

Joint Venture Reporting

The revisions have changed the basis for reporting interests in joint ventures and other investment partnerships. Reporting organizations will now be required to report revenues and expenses related to such partnership arrangements using amounts provided by the partnership on Schedule K-1, rather than amounts derived from the organization's books and records. Further, Part X of the revised Form 990 requires a reporting organization to report its distributive shares of assets in such partnership arrangements according to its ending capital account as reflected on the partnership's Schedule K-1.

Governance and Compensation

The revised Form 990 requires tax-exempt organizations to report certain governance matters. In Part VI of the Form 990, tax-exempt organizations must explain any broad delegation by a governing body to an executive committee. Reporting organizations are also now required to list the governance decisions that are reserved to, or subject to the approval of, members, stockholders, or other persons. Revisions were also made to the officer and employee compensation reporting requirements in Part VII of the Form 990.

Needs Assessment

For tax year 2010, the IRS revised Schedule H to comply with the PPACA amendments to the Code, which includes numerous additional reporting requirements for organizations that operate tax-exempt hospitals. Such revisions included the addition of a 21-question section on facility policies and practices (Facility Policies and Practices Section). The Facility Policies and Practices Section requires organizations that operate tax-exempt hospitals to report data related to their financial assistance policies, billing and collection, emergency medical care, and financial assistance eligibility.

For tax year 2011, the IRS made some minor clarifications and revisions to the Facility Policies and Practices Section. Notable changes from tax years 2010 to 2011 include the following:

- Requiring that a tax-exempt hospital explain the criteria used to determine eligibility for free and discounted care under the hospital's financial assistance policies (FAPs)
- Replacing the requirement that a tax-exempt hospital describe the methods for charging and billing individuals without insurance with a requirement that a hospital describe how it determines the maximum amounts to be charged to FAP-eligible individuals
- Replacing the requirement that a tax-exempt hospital report if it charged any of its patients an amount equal to the gross charge for services with a requirement that a tax-exempt hospital report if it charged any FAP-eligible individuals an amount equal to the gross charge of the services received by such individual

Tax-exempt organizations may wish to consider familiarizing themselves with these revisions to prepare to meet the most recent IRS filing requirements.

CMS CLARIFIES "FOR CAUSE" MEDICAID TERMINATION RULE

The Centers for Medicare & Medicaid (CMS) recently released an informational bulletin (the Bulletin) to clarify previous CMS guidance regarding mandatory termination of provider participation in state Medicaid programs after such provider has been terminated from participation in the Medicare program or any other state Medicaid program or plan.

The Patient Protection and Affordable Care Act (PPACA), as amended, requires states to terminate the participation of any individual or entity who is a Medicaid provider if such individual or entity has been terminated from participation in the Medicare program or another state Medicaid plan. Although the PPACA provision does not apply to individuals or entities participating in a state Children's Health Insurance Program (CHIP), CMS has imposed a similar termination requirement for CHIP participants. To implement this provision, CMS has developed a web-based application accessible to the states. States must upload terminations to the application and download other state's terminations from the application and are

encouraged to do so on a monthly basis.

The regulations implementing the mandatory termination provision of PPACA apply to terminations where a provider or supplier has exhausted all appeals and where such terminations are "for cause." The regulations and previous CMS guidance defined "for cause" terminations as those based on fraud, integrity, or quality. This Bulletin clarifies the regulations by providing examples of "for cause" terminations. The examples listed include providers terminated by state Medicaid agencies as a result of the following:

- A report to the National Practitioner Data Base as a result of adverse licensure actions
- Fraudulent conduct
- An abuse of billing privileges
- Misuse of their billing number
- Falsification of information on enrollment applications or information submitted for enrollment
- Billing after suspension or revocation of the provider's medical license
- Falsification of medical records that support services billed to Medicaid

As maintained in previous CMS guidance, "for cause" terminations do not include voluntary terminations, except when such voluntary termination is made to avoid sanction, or terminations due to inactive or expired medical licenses when a provider has relocated to another state. However, such examples are intended as guidance, and states are permitted to interpret their own laws to define "for cause" termination. States may request a waiver from CMS to exclude a provider from the mandatory termination requirement if the provider is the only source of essential services in the community and such termination imposes a hardship on Medicaid beneficiaries.

AHA ISSUES GUIDELINES FOR CHANGES IN HOSPITAL OWNERSHIP

On January 17, 2012, the American Hospital Association (AHA) issued *Principles and Guidelines for Changes in Hospital Ownership* (Guide). The Guide sets out a series of voluntary guidelines to assist hospital and health system leaders as they consider and approach a merger, an acquisition, or the development of an integrated delivery system or accountable care organization. The Guide focuses on three key areas: (1) the fiduciary duties of the board of directors to ensure its actions further the hospital's mission; (2) key considerations for potential changes in ownership or control to ensure the needs of the community are balanced with the needs of the organization for adaptation; and (3) guidelines for review of a potential change in ownership or control.

Fiduciary Duties of the Board of Directors

The Guide outlines eight items, listed below, which directors may wish to consider focusing on to ensure they are meeting their fiduciary duties and to ensure they remain active and independent as they engage in the analysis of a potential change in ownership or control.

- Understand the community's need for health care services and determine the best organizational structure for meeting those needs
- Prepare in advance for meetings about potential changes in ownership or control of

the hospital by reading relevant reports regarding these potential changes and any other options considered
- Participate actively in board and committee meetings by questioning hospital executives, legal counsel, and other consultants about changes in ownership and control
- Exercise independent judgment in votes pertaining to the potential change in ownership and control
- Establish written policies for addressing conflicts of interest
- Recuse directors from activities that may compete with the hospital or impeded its ability to determine whether a change of control is in the hospital's best interest
- Avoid diverting opportunities available to the hospital to preserve or protect a personal or financial interest
- Follow-up on outstanding questions throughout the decision-making process

Needs of the Community vs. Needs of the Organization

The Guide notes that as the board is reviewing the various options for a potential change in ownership or control, it is important that it balance the needs of the community for efficient and effective health care services with the needs of the organization to adapt to the changing regulatory environment. The Guide offers the following sixteen questions for the board to ask of itself and the other parties as it explores the options to ensure all constituent needs are met:

- Why is the transaction being considered?
- Will this transaction help to fulfill the hospital's mission?
- Will the boards (local and system, if applicable) be receptive to the proposed change?
- Is the change consistent with the hospital's strategic planning?
- What are the financial advantages and disadvantages of the proposal?
- What are the internal and external political consequences of the change in ownership or control?
- Will the medical staff and other professionals be receptive to the idea? How will the community respond to the proposed change?
- How will the changes be communicated to key constituencies?
- Are there any legal or regulatory constraints that may hinder the proposal?
- Are any constraints imposed by existing collective bargaining agreements?
- Are there any tax-exempt bonds or other debt covenants that may be triggered by the potential change?
- Have all potential liabilities been disclosed?
- Are there quality of care issues and, if so, how will they be addressed?
- How will the new organization be structured?
- What are the selection criteria for the management team?
- What are the selection criteria for governance?

Guidelines for Review

Finally, the Guide provides seven guidelines to help the directors and hospital and system leaders meet the challenges and address the issues that are frequently encountered when an organization considers a change in ownership or control. These guidelines are outlined below.

1. **Engage the community to identify its future health improvement needs**: The hospital or system leaders should determine the most appropriate way to engage its

constituents and interested parties in the change of ownership or control process to ensure any potential changes meet the constituents' needs and to help facilitate implementation strategies.

2. **Establish initial steps in considering a change in ownership or control**: The hospital or system leaders should adopt strategic plans and objectives to ensure a change in ownership or control will further its core values and goals.
3. **Carefully evaluate proposed changes in ownership or control**: The hospital or system leaders should develop policies and procedures for use by task forces to review, evaluate, and make recommendations regarding proposals to partner with other hospitals and health systems. The Guide provides a sample checklist of items to collect and review during the due diligence phase.
4. **Conduct an appropriate review of state and federal health laws**: The hospital or system leaders need to ensure compliance with all state and federal laws relating to health care and, as appropriate, tax exemption.
5. **Conduct an appropriate antitrust analysis where necessary**: The hospital or system leaders must evaluate whether or not the party with whom it is considering entering into an agreement is a competitor and if a change in ownership or control will impact antitrust laws. The hospital must also keep in mind that transactions over a certain size must be reported to the federal antitrust agencies.
6. **Protect the value of the community's assets**: Tax-exempt, charitable organizations, hospitals and health systems are subject to review by state attorneys general or other agencies. Hospital and health system leaders must ensure compliance with these review processes where applicable.
7. **Educate and inform the community about the changes taking place**: Hospitals and health systems should develop a comprehensive communications plan that addresses each of the constituencies affected by the proposed change in ownership or control.

The key takeaway from the Guide is that hospital and system leaders need to be aware of the impacts of any change to ownership or control related to the hospital or health system. Such changes can affect a large variety of constituents and will require compliance with various local, state, and federal laws and regulations.

HEALTH CARE EMPLOYEE WHISTLEBLOWER PROTECTION STATUTE PROVIDES PRIVATE RIGHT OF ACTION

In a case of first impression, a Connecticut Superior Court recently ruled that Conn. Gen. Stat. §19a-498a, which prohibits discrimination against whistleblowers in health care facilities, provides a private right of action for employees who allege such discrimination. The lawsuit, *Carlson v. Sheriden Woods Health Care Center, Inc.* (Health Center), was brought by a nurse employed by the Health Center (Nurse) who alleged that she was inappropriately terminated after reporting concerns about patient health and safety at the Health Center.

In June 2011, the Nurse reported an incident concerning patient safety to the head administrator of the Health Center and ensured that the incident was properly documented in compliance with state and federal regulations. At the time that the Nurse reported the incident, the Health Center was under ongoing monitoring by the Connecticut Department of Public Health. Her employment was subsequently terminated by the Health Center. In response, the Nurse filed claims against the Health Center for (1) a violation of Conn. Gen. Stat. §19a-498a, (2) wrongful termination, and (3) breach of the implied covenant of good faith and fair dealing.

The Nurse's §19a-498a claim was based upon her allegation that she was terminated by the Health Center because she reported her concerns about patient safety. The Health Center moved to strike all of the Nurse's claims and argued that §19a-498a does not create a private cause of action.

Conn. Gen. Stat. §19a-498a prohibits a health care facility from discriminating or retaliating against an employee who submits a complaint or initiates or cooperates in an investigation by a governmental entity that relates to the care or services provided by, or the conditions in, such facility. A health care facility found to have engaged in such discriminatory or retaliatory conduct must reinstate the terminated employee and must also reimburse such employee for lost wages, lost benefits, and reasonable attorney's fees incurred by the employee in pursuing the employee's rights under the statute.

The Court held that §19a-498a creates a private right of action for employees who allege discrimination and retaliation by an employer health care facility. Specifically, the Court reasoned that (1) health care facility employees are part of the class for whose benefit the statute exists; (2) the inclusion of a reimbursement provision in the statute suggests that an employee must file suit and obtain a judgment before the employer becomes responsible for reimbursing such employee; (3) an implied right of action is not inconsistent with the statute; and (4) an implied right of action keeps §19a-498a consistent with other Connecticut wrongful termination and retaliation laws, each of which authorizes a private right of action.

The Court ultimately found that the Nurse failed to adequately plead a cause of action under §19a-498a because she failed to allege facts to establish that she assisted or cooperated in an investigation of the Health Center by a governmental entity, as is required by the statute. As a result, the Court granted the Health Center's motion to strike the Nurse's claim.

Although the Court granted the Health Center's motion to strike, the Court's analysis of the relevant issue demonstrates a willingness on the part of the Superior Court to recognize a terminated employee's private right of action for a violation of Conn. Gen. Stat. §19a-498a. This ruling may have an impact on future claims filed against employer health care facilities by employees who allege that they have been discriminated or retaliated against by such health care facilities in violation of §19a-498a.

If you have questions about any of these topics, please contact a member of Robinson & Cole's Health Law Group.

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