



## Hot Off the Feds' Press: The Latest HIPAA and HITECH Act Developments

by William H. Maruca



It's been a busy summer for regulation of electronic health records and health privacy. Proposed and final regulations provided guidance on such hot topics as who is covered by HIPAA privacy and security rules; who is a

business associate; what will qualify as "meaningful use" of EHR for the HITECH subsidies; and what documents need to be updated. The following is a short summary of the latest changes in this volatile environment. For current updates, please visit our [HIPAA, HITECH and HIT blog](#).

### "Meaningful Use" Final Rule

Under the Health Information Technology for Economic and Clinical Health Act (HITECH), federal incentive payments will be available to doctors and hospitals when they adopt EHRs and demonstrate use in ways that can improve quality, safety and effectiveness of care. Eligible professionals can receive as much as \$44,000 over a five-year period through

Medicare. For Medicaid, eligible professionals can receive as much as \$63,750 over six years. Medicaid providers can receive their first year's incentive payment for adopting, implementing and upgrading certified EHR technology but must demonstrate meaningful use in subsequent years in order to qualify for additional payments. The amount a hospital receives in EHR incentive payments is calculated based on the hospital's Medicare and Medicaid patient volume, calculated as a fraction of the hospital's total patient volume.

On July 13, 2010, the Department of Health and Human Services (HHS) released a pair of final regulations (one from CMS, one from the Office of National Coordinator for HIT) detailing the "meaningful use" criteria that will determine whether users of electronic health records will qualify for the government subsidies under the HITECH Act during the first two years of the program (2011-2012). The final rule modified the agency's January 16, 2010, proposed rule and addressed issues raised in the more than 2,000 comments submitted.

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The agency responded to the numerous complaints that its earlier, all-or-nothing approach mandating 25 objectives (23 for hospitals) was unrealistic. Instead, the final proposal requires 15 "core" objectives and a menu of additional objectives EHR users can choose from to qualify for the financial help.

The 15 core objectives and the measurements used to determine if they have been met are as follows:

OBJECTIVE	MEASURE
1. Record patient demographics (sex, race, ethnicity, date of birth, preferred language and, in the case of hospitals, date and preliminary cause of death in the event of mortality).	More than 50% of patients' demographic data recorded as structured data.
2. Record vital signs and chart changes (height, weight, blood pressure, body-mass index, growth charts for children).	More than 50% of patients two years of age or older have height, weight and blood pressure recorded as structured data.
3. Maintain up-to-date problem list of current and active diagnoses.	More than 80% of patients have at least one entry recorded as structured data.
4. Maintain active medication list.	More than 80% of patients have at least one entry recorded as structured data.
5. Maintain active medication allergy.	More than 80% of patients have at least one entry recorded as structured data.
6. Record smoking status for patients 13 years of age or older.	More than 50% of patients 13 years of age or older have smoking status recorded as structured data.
7. For individual professionals, provide patients with clinical summaries for each office visit. For hospitals, provide an electronic copy of hospital discharge instructions on request.	Clinical summaries provided to patients for more than 50% of all office visits within three business days. More than 50% of all patients who are discharged from the inpatient department or emergency department of an eligible hospital or critical access hospital and who request an electronic copy of their discharge instructions are provided with it.

## Staying Well Within the Law

OBJECTIVE	MEASURE
8. On request, provide patients with an electronic copy of their health information (including diagnostic test results, problem list, medication lists, medication allergies and, for hospitals, discharge summary and procedures).	More than 50% of requesting patients receive electronic copy within three business days.
9. Generate and transmit permissible prescriptions electronically (does not apply to hospitals).	More than 40% are transmitted electronically using certified EHR technology.
10. Computer provider order entry (CPOE) for medication orders.	More than 30% of patients with at least one medication in their medication list have at least one medication ordered through CPOE.
11. Implement drug–drug and drug–allergy interaction checks.	Functionality is enabled for these checks for the entire reporting period.
12. Implement capability to electronically exchange key clinical information among providers and patient–authorized entities.	Perform at least one test of EHR’s capacity to electronically exchange information.
13. Implement one clinical decision support rule and ability to track compliance with the rule.	One clinical decision support rule implemented.
14. Implement systems to protect privacy and security of patient data in the EHR.	Conduct or review a security risk analysis, implement security updates as necessary, and correct identified security deficiencies.
15. Report clinical quality measures to CMS or states.	For 2011, provide aggregate numerator and denominator through attestation. For 2012, electronically submit measures.

The “menu” from which an additional five objectives may be selected, and the criteria for meeting those objectives, are as follows:

OBJECTIVE	MEASURE
1. Implement drug formulary checks.	Drug formulary check system is implemented and has access to at least one internal or external drug formulary for the entire reporting period.
2. Incorporate clinical laboratory test results into EHRs as structured data.	More than 40% of clinical laboratory test results whose results are in positive/negative or numerical format are incorporated into EHRs as structured data
3. Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research or outreach.	Generate at least one listing of patients with a specific condition.
4. Use EHR technology to identify patient–specific education resources and provide those to the patient as appropriate.	More than 10% of patients are provided patient–specific education resources.
5. Perform medication reconciliation between care settings.	Medication reconciliation is performed for more than 50% of transitions of care.
6. Provide summary of care record for patients referred or transitioned to another provider or setting.	Summary of care record is provided for more than 50% of patient transitions or referrals.
7. Submit electronic immunization data to immunization registries or immunization information systems.	Perform at least one test of data submission and follow–up submission (where registries can accept electronic submissions).
8. Submit electronic syndromic surveillance data to public health agencies.	Perform at least one test of data submission and follow–up submission (where public health agencies can accept electronic data).
<b>Additional Choices for Hospitals and Critical Access Hospitals:</b>	
9. Record advance directives for patients 65 years of age or older.	More than 50% of patients 65 years of age or older have an indication of an advance directive status recorded.
10. Submit electronic data on reportable laboratory results to public health agencies.	Perform at least one test of data submission and follow–up submission (where public health agencies can accept electronic data).
<b>Additional Choices for Eligible Professionals:</b>	
9. Send reminders to patients (per patient preference) for preventive and follow–up care.	More than 20% of patients 65 years of age or older or 5 years of age or younger are sent appropriate reminders.
10. Provide patients with timely electronic access to their health information (including laboratory results, problem list, medication lists, medication allergies).	More than 10% of patients are provided electronic access to information within four days of its being updated in the EHR.

A rollout article in the *New England Journal of Medicine* was written by HHS's David Blumenthal, M.D., M.P.P., national coordinator for HIT, and Marilyn Tavenner, R.N., M.H.A., principal deputy administrator of CMS, both of whom participated in the development of the final rule. They noted the core objectives include the tasks essential to creating any medical record, including the entry of basic data: patients' vital signs and demographics, active medications and allergies, up-to-date problem lists of current and active diagnoses and smoking status, as well as using several software applications that begin to realize the true potential of EHRs to improve the safety, quality and efficiency of care, help clinicians to make better clinical decisions and avoid preventable errors.

### What To Do Now?

Software and EHR systems developers are scrambling to ensure their products will meet the meaningful use standards by 2011. Practices and facilities that desire to take advantage of the federal funding should start shopping early and ask potential vendors to address in writing exactly how their products can satisfy each of the criteria in the new standards.

Hospitals face an additional issue: They must be careful in how they report charity care on their Medicare cost reports if they want to maximize their incentive payments for using EHR. The amount a hospital receives in EHR incentive payments is calculated based on the hospital's Medicare and Medicaid patient volume, calculated as a fraction of the hospital's total patient volume. The rule proposal failed to define key terms that are part of the calculation of the fractional share of the hospital's Medicare and Medicaid patient volume, including the term "charity care." The proposed final rule looks to the charity care amount reported in the hospital's Medicare cost report, despite the fact this reported number likely did not have a significant impact on the hospital's Medicare reimbursement in the past. Any hospital seeking EHR incentive payments must closely examine not just the accuracy of reported charity care and non-Medicare bad debt data included on its Medicare cost report, but must ensure it is actually undertaking a review of patients' ability to pay for services. Failure to document the proportion of uncompensated care that

qualifies as "charity care" may result in a decrease in EHR incentive dollars.

### Proposed HITECH Rule

On July 8, 2010, HHS announced proposed modifications to the HIPAA Privacy & Security Rules implementing the HITECH Act. The proposed modifications include new requirements on business associates with regard to their subcontractors.

The HITECH statute itself imposed direct HIPAA compliance obligations and liability on business associates. The proposed rule goes one step further and would include in the definition of "business associate" in §160.103 subcontractors that create, receive, maintain or transmit protected health information on behalf of a business associate. OCR specifies it does not intend this proposed modification to mean a covered entity is required to have a contract with the subcontractor. Rather, the "obligation is to remain with the business associate that contracts with the subcontractor." OCR proposes "to make clear that it is the business associate that must obtain the required satisfactory assurances from the subcontractor to protect the security of electronic protected health information."

The proposed rule casts business associates into a much more active role, requiring them to enter into business associate agreements (BAAs) with their subcontractors. In effect, business associates would be expected to act as though they are covered entities in terms of identifying when protected health information (PHI) is transmitted to third parties and policing the privacy and security of PHI whenever it flows downstream or outside the business associate workforce.

Because a covered entity with which a business associate has contracted still has an ultimate responsibility for the privacy and security of the PHI of its patients or clients, existing BAAs may require further review and amendments to protect the covered entity sufficiently should this rule be adopted.

The proposed rule expands individuals' rights to access their information and to restrict certain types of disclosures of PHI to health plans. It also sets new limitations on the use and disclosure of PHI for marketing and fund-raising and prohibits the sale of PHI without patient authorization.

### Final Breach Rule Withdrawn, Interim Rule Remains in Effect

In an unexpected development, HHS withdrew its forthcoming Final Breach Notification Rule, which was pending review by the Office of Management and Budget, on July 28, 2010. In a brief announcement, HHS stated the delay was intended to allow for further consideration, given the Department's experience to date in administering the regulations. They stated, "This is a complex issue and the Administration is committed to ensuring that individuals' health information is secured to the extent possible to avoid unauthorized uses and disclosures, and that individuals are appropriately notified when incidents do occur. We intend to publish a final rule in the Federal Register in the coming months."

Some privacy advocates have been lobbying HHS over the rule's "harm standard," which states that health care organizations only have to report HIPAA privacy and security breaches to OCR if the covered entity determined the breach caused direct harm to the affected patients. Such advocates believed this rule gave too much discretion to the covered entities themselves.

In the meantime, the Interim Final Rule for Breach Notification for Unsecured Protected Health Information, effective September 23, 2009, remains in effect. This rule requires HIPAA covered entities to promptly notify affected individuals of a breach. Covered entities that experience a breach affecting more than 500 residents of a state or jurisdiction are, in addition to notifying the affected individuals, required to provide notice to prominent media outlets serving the state or jurisdiction. These notices must be made without unreasonable delay and in no case later than 60 days following the discovery of a breach. If a breach affects 500 or more individuals, covered entities must notify the Secretary of HHS without unreasonable delay and in no case later than 60 days following a breach. Breaches affecting fewer than 500 individuals will be reported to the HHS Secretary on an annual basis. The regulations also require business associates of covered entities to notify the covered entity of breaches at or by the business associate.

### If You Experience a Breach...

- First, document when and how the breach was discovered. This date starts

the compliance clock ticking.

Remember, notice must be given as soon as possible, so do not wait until the 59th day.

- Next, determine whose records were compromised, how the breach occurred and what information was improperly accessed or disclosed.
- Determine what notices need to be given, to whom, in what form and including what details.
- Establish a plan for making the required notices and implement it. Follow up with appropriate mitigation efforts.
- Consider providing additional protection to the affected individuals. While optional, many organizations have chosen to offer prepaid identity monitoring, protection and remediation services via third-party vendors as a goodwill gesture and to soften the public relations fallout.

At each step of the process, consultation with experienced health care counsel will help you understand and meet your obligations under the law and minimize the consequences of the breach.

Thanks to [Elizabeth Litten](#), whose work contributed to this article.

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## What Makes a Hospital “Charitable?” Billing and Collection Issues for Charitable Hospitals Post-PPACA

by [Elizabeth G. Litten](#) and [Steven J. Link](#)



### New Requirements for Charitable Hospitals in the Patient Protection and Affordable Care Act (PPACA)

Buried in PPACA is a section titled simply, “Additional Requirements for Charitable Hospitals.” This section revokes a charitable hospital’s tax-exempt status under section 501(c)(3) of the Internal Revenue Code (IRC) of 1986 if the hospital fails to meet any of four specific requirements.

First, a charitable hospital must conduct a **community health needs assessment** once every three years (in the taxable year or in either of the two years preceding the taxable year) and must adopt an “implementation strategy to meet the community health needs identified” by the assessment. The assessment must take into account input from “persons who represent the broad interests of the community served” by the hospital, including those with a knowledge of or expertise in public health, and *it must be made widely available to the public*.

Second, the hospital must have a **financial assistance policy** that includes: (1) eligibility criteria for financial assistance, and whether the assistance includes free or discounted care; (2) the basis for calculating

amounts charged to patients; (3) the method for applying for financial assistance; (4) if the hospital does not have a separate billing and collections policy, the actions the hospital may take in the event of non-payment, including collections actions and reporting to credit agencies; and (5) measures *to widely publicize the policy within the community to be served by the hospital*.

Third, the hospital must implement **limitations on charges**. The amounts charged by hospitals for emergency or other medically necessary care to patients eligible for assistance under the financial assistance policy must be limited to amounts that are not more than those charged to patients who have insurance, and hospitals are prohibited from “the use of gross charges.” The staff of the Joint Committee on Taxation (JCT) explains the “limitation on charge” requirement this way in its March 21, 2010, report (JCT Report):

Each hospital facility is permitted to bill for emergency or other medically necessary care provided to individuals who qualify for financial assistance under the facility’s financial assistance policy no more than the amounts generally billed to individuals who have insurance covering such care. A hospital facility may not use gross charges (i.e., “chargemaster” rates) when billing individuals who qualify for financial

assistance. It is intended that amounts billed to those who qualify for financial assistance may be based on either the best, or an average of the three best, negotiated commercial rates, or Medicare rates. [JCT Report, p. 82]<sup>1</sup>

Fourth, and finally, the hospital must have a **billing and collection** policy that requires it to make “reasonable efforts” to determine whether the patient is eligible for assistance under the financial assistance policy before taking “extraordinary collection actions.” For example, if an insured patient has a high deductible or co-insurance amount, the hospital must determine whether the patient qualifies for financial assistance *before* it bills the patient, as qualification may impact the dollar amount the hospital is permitted to bill.<sup>2</sup>

Penalty for noncompliance is high: loss of tax-exempt status, compounded by a penalty (or “excise tax”) of \$50,000 per year for failure to satisfy the **community health needs assessment** requirements. It will be up to the IRS to adopt regulations setting forth the parameters for hospital compliance with these PPACA mandates. The IRS recently published Notice 2010-39 – “*Request for Comments Regarding Additional Requirements for Tax-Exempt Hospitals*” (<http://www.irs.gov/pub/irs-drop/n-10-39.pdf>). Comments were due for submission to the IRS by July 22, 2010.

<sup>1</sup> Note also that Section 2719A of PPACA, “Patient Protections,” provides that emergency services must be covered by insurers in a manner that does not discriminate against a patient using an out-of-network hospital. The patient’s “cost-sharing requirement (expressed as a co-payment amount or co-insurance rate) ... [must be] the same requirement that would apply if such services were provided in-network.”

<sup>2</sup> Hospitals that routinely screen patients for charity care or government-sponsored program eligibility may believe they meet (or may, in fact, actually meet) the requirement that they make “reasonable efforts” to determine whether patients qualify for financial assistance, but a hospital should evaluate its financial assistance policy to see whether patients who do not qualify for government assistance or government-sponsored programs may still be eligible for discounted or free care. If a “reasonable effort” is not made to communicate the parameters of the hospital’s financial assistance policy to each and every patient (for example, if “reasonable efforts” are only made for patients thought to be eligible for government assistance or government-sponsored programs), the hospital should be wary of sending any patient’s account to a collection agency.

Notably, sections 501(r)(5) and (6), the sections requiring limitations on hospital charges and billing and collections policies, respectively, take effect for tax years beginning after March 23, 2010 (the date of enactment of PPACA).

### The Evolution of Tax-Exemption Under §501(c)(3)

Hospitals are exempt from federal taxation if they are “organized and operated exclusively for . . . charitable . . . purposes.” IRC § 501(c)(3). The IRS first interpreted this language in 1956 to require hospitals to provide free or discounted medical services to maintain their tax-exempt status.<sup>3</sup> This interpretation lasted for 14 years before Revenue Ruling 69-545 came down. In what became known as the “community benefit” standard, the IRS ruled that hospitals maintain their tax-exempt status not by providing a required minimum level of charity care, but through promotion of health for the benefit of the community.<sup>4</sup> Determinations of a hospital’s tax-exempt status, therefore, were fact sensitive, requiring a case-by-case analysis. *Id.* However, it appeared that, under this interpretation of the statute, hospitals could maintain their tax-exempt status without providing any specific level or quantity of charitable or discounted service.<sup>5</sup>

This seemingly amorphous language plagued the IRS for years. For example, Revenue Ruling 83-157 attempted to clarify Revenue Ruling 69-545 by determining that having a fully operational emergency room was not required for tax-exemption, but was merely one of several factors that could be considered.<sup>6</sup> However, it remained the IRS’ position under the “community benefit” standard that charitable care was not a requisite for tax exemption.

To begin to shift that policy position, in Field Service Advice (FSA) 200110030<sup>7</sup> the IRS determined that the promotion of

health and mere adoption of a charity care policy is not enough to maintain tax-exempt status.<sup>8</sup> The IRS identified 14 factors to consider for a hospital to maintain its tax-exempt status; for example, the IRS determined that the hospital’s charity care policy must be communicated to the public, that a reasonable amount of charity care must be provided and that charity care patients cannot be routinely discriminated against. *Id.* Furthermore, in its 2002 Healthcare Update, the IRS reaffirmed that the implementation of a charity care policy is a “highly significant factor” to satisfy the “community benefit” standard. *Id.* Thus, providing free or discounted medical services remained very important to attaining or maintaining tax-exempt status.

### The Genesis of the Requirements for Charitable Hospitals in PPACA

Hospitals’ pricing policies began to be scrutinized in 2004. In June 2004, the House Ways and Means Subcommittee on Oversight and the Energy and Commerce Subcommittee on Oversight and Investigations held hearings reviewing the pricing and billing and collections procedures of hospitals.<sup>9</sup> Spearheading the effort to reform the standards for obtaining and maintaining tax-exempt status was Senator Charles Grassley. Given the IRS’ amorphous “community benefit” standard, Grassley’s goal was to encourage hospitals to proffer their own reform proposals so providers would produce a single definition of charity care and identify a requisite level of care necessary for tax exemption.<sup>10</sup>

Grassley’s efforts began on May 25, 2005, by writing a letter to 10 nonprofit hospitals asking them to justify their § 501(c)(3) tax exemptions.<sup>11</sup> His several questions related to each hospital’s charitable care efforts and the reasonableness of their discriminatory pricing schemes for medical care. See *id.* The answers to these questions would assist

Congress in “considering the issues of tax-exempt organizations and particularly the duties and requirements of public charities in relation to the billions of dollars in tax benefits that tax-exempt organizations receive at the federal, state, and local level.” *Id.* The IRS initiated its own investigation in April 2006 by sending questionnaires to almost 600 hospitals to determine how each satisfied the “community benefit” standard.<sup>12</sup>

In an effort to establish a definable standard for tax exemption, on March 8, 2006, Grassley wrote a letter to the AHA asking how Congress should define “care for the needy.” Quirk, *supra*, at 91. Concerned for the financial well-being of hospitals and arguing that hospitals were already in compliance with Revenue Ruling 69-545, Senior Vice President for Federal Regulations Thomas Nickels expressed hesitation about any new laws further regulating requirements under § 501(c)(3). *Id.*

In addition to seeking definable standards, Grassley also sought to improve transparency so the public could evaluate the charitable acts of various hospitals. On May 29, 2007, Grassley wrote a letter to Treasury Secretary Henry Paulson urging him to update Form 990 since it “has not kept up with modern practices in the charitable sector.”<sup>13</sup> Grassley recommended that the form include “more detailed questions tailored to the specifics of their fields if transparency and openness are to have real value.” *Id.*

As a result of these recommendations, in December 2007, Form 990 and its accompanying schedules were ultimately revised. Schedule H was created and applied only to tax-exempt hospitals. Specifically relevant, Part I of Schedule H requires tax-exempt hospitals to report the total amount of “Charity Care and Certain Other Community Benefits at Cost.” (Emphasis added). The Instructions for Part I of Schedule H reiterate that Part I “requires reporting of . . . the cost of certain charity care

<sup>3</sup> See Rev. Rul. 56-185, 1956-1 C.B. 202.

<sup>4</sup> Rev. Rul. 69-545, 1969-2 C.B. 117.

<sup>5</sup> See Lisa Kinney Helvin, Caring for the Uninsured: Are Not-For-Profit Hospitals Doing Their Share? 8 *Yale J. Health Pol’y L. & Ethics* 421, 442 (2008).

<sup>6</sup> Rev. Rul. 83-157, 1983-2 C.B. 94.

<sup>7</sup> Note that FSAs have no precedential value.

<sup>8</sup> Leah Snyder Batchis, Comment, Can Lawsuits Help the Uninsured Access Affordable Hospital Care? Potential Theories for Uninsured Patient Plaintiffs, 78 *Temp. L. Rev.* 493, 511 (2005).

<sup>9</sup> See Carol Pryor et al., Access Project & Cmty. Catalyst, Best Kept Secrets: Are Non-Profit Hospitals Informing Patients About Charity Care Programs? 6 (2010). The goal of this project was to randomly survey 99 hospitals to determine if hospitals were generally complying with the American Hospital Association’s (AHA) voluntary guidelines to make their financial assistance policies public, communicate the policies to patients in a meaningful and easily understandable way, and have easily understandable written policies for patients to determine if they qualify for financial assistance. See Pryor et al., *supra*, at 2. It was found that: (1) 85 hospitals mentioned the availability of charity care; (2) 42 hospitals provided application forms; (3) 26 hospitals provided information regarding eligibility criteria for charity care; and (4) 34 hospitals provided information in a language other than English. *Id.* at 3.

<sup>10</sup> See John M. Quirk, Turning Back the Clock on the Health Care Organization Standard for Federal Tax Exemption, 43 *Willamette L. Rev.* 69, 89 (2007) (attempts to quantify charity care under state law).

<sup>11</sup> See Press Release, Senator Chuck Grassley, Grassley Asks Non-Profit Hospitals to Account for Activities Related to Their Tax-Exempt Status (May 27, 2005).

<sup>12</sup> Marilyn E. Phelan, Nonprofit Organizations: Law and Taxation §21:13 (2010).

<sup>13</sup> See Press Release, Senator Chuck Grassley, Sen. Grassley Works to Build Confidence in Nonprofits With Greater Transparency (May 29, 2007).

and other community benefit programs.” (Emphasis added). These new federal reporting standards reflecting the cost of care, as opposed to the fees charged for medical services, “establish . . . a uniform framework for how hospitals nationwide must report aggregate community benefit and related information on billings and collections, including data on charity care, benefits to the community, ‘community building’ activities, Medicare underpayments, bad debt expenses, and emergency department policies and procedures.” Helvin, *supra*, at 448.

In 2009, Grassley converted his years of research into drafts of several legislative reforms that attempted to clarify the requirements for tax-exempt status under § 501(c)(3).<sup>14</sup> Support for Grassley’s legislative reforms transcended party affiliations.<sup>15</sup> These same provisions were included in § 9007 of the PPACA; ironically, however, Grassley ultimately voted against PPACA.<sup>16</sup>

### Patients’ Attempts To Enforce §501(c)(3) in Federal Court

Several complaints have been filed in federal court by uninsured, indigent patients for monetary damages against tax-exempt hospitals that charge uninsured patients medical fees significantly exceeding the fees charged to privately insured patients or patients covered by Medicare or Medicaid.<sup>17</sup> Generally, the complaints alleged:

- (1) [T]hird-party breach of contract between hospitals and the federal government;
- (2) third-party beneficiary claims for breach of the same alleged contract;
- (3) breach of duty of good faith and fair dealing, based on the alleged contract;
- (4) breach of charitable trust for failure to provide affordable medical care to the uninsured in exchange for federal, state and local tax exemption; and
- (5)

unjust enrichment and constructive trust, also based on the theory that the hospitals owed a duty to provide affordable medical care to the uninsured in exchange for federal, state and local tax exemptions.

Helvin, *supra*, at 435. All federal courts have held that plaintiffs fail to establish standing to sue under § 501(c)(3). *Id.*; see, e.g., *Lorens v. Catholic Health Care Partners*, 356 F. Supp. 2d 827 (N.D. Ohio 2005). After finding plaintiffs failed to establish standing, courts have uniformly rejected each claim on the merits.<sup>18</sup> Therefore, patients have been unsuccessful in challenging discriminatory pricing schemes in federal court.

It is worth noting that federal courts have also held that federal law does not prohibit “balance billing” Medicare patients charges for medical services after primary Medicare and Medigap coverage has been exhausted. See *Vencor, Inc. v. Physicians Mut. Ins. Co.*, 211 F.3d 1323 (D.C. Cir. 2000). The court concluded that 42 U.S.C. § 1395cc(a)(1)(A) had “nothing to do with charges for post-Medicare services” and “[s]o radical a scheme as imposition of price controls on medical services not covered by Medicare requires explicit language, not mere brooding purposes.” *Id.* at 1325-26. On the other hand, at least one New Jersey court has held that “state[s] . . . may lawfully enact a regulatory scheme which, in part, limits the ‘appropriate standard of payment’ by a Medigap patient to the DRG payment.” *Valley Hosp. v. Kroll*, 847 A.2d 636, 644 (N.J. Super. Ct. Law Div. 2003).<sup>19</sup> Finding the hospital’s balance billing policy constituted a contract of adhesion and therefore was unenforceable, the court ultimately determined that the amount paid to the hospital by the Medigap insurer was reasonable under state law. *Id.* at 652.

### States’ Attempts To Quantify “Community Benefit” Under State Law

As a result of the inherent vagueness of the “community benefit” standard, several states have attempted to quantify the level of charity care required to qualify for tax-exempt status under state law.<sup>20</sup> Recent case law in Illinois is illustrative. In *Provena Covenant Med. Cent. v. Dep’t. of Revenue*, 236 Ill. 2d 368 (Ill. 2010), Provena Covenant Medical Center (PCMC) employed a pricing scheme in 2002 that charged uninsured patients “established rates, which were more than double the actual costs of care” while charging privately insured patients or patients enrolled in Medicare or Medicaid discounted rates for the same medical care. *Id.* at 400. Additionally, only 302 of its approximately 110,000 total patients received charitable medical care at a reduced price. *Id.* at 382. Furthermore, PCMC only waived \$831,724 in actual costs (0.723 percent of total revenue) for medical services, yet received \$1.1 million in property tax exemptions. *Id.* at 381. Given these facts, among others, the Illinois Supreme Court held that PCMC failed to qualify as a tax-exempt hospital for purposes of a state property tax exemption. *Id.* at 411.

Another example of an attempt to define requirements related to charity care can be found in Texas, which has, in part, codified its quantitative requirements for charity care.<sup>21</sup> Under Tex. Health & Safety Code Ann. § 311.045 (a) (Vernon 2010), a tax-exempt hospital must meet the standards set forth in subsection (b) to satisfy its charity care requirements. Subsection (b) states that hospitals can satisfy the charity care requirement by providing charity care and government-sponsored indigent health care in one of three ways: (1) “at a level which is

<sup>14</sup> See Press Release, Senator Chuck Grassley, Grassley’s Provisions for Tax-Exempt Hospital Accountability Included in New Health Care Law (Mar. 24, 2010).

<sup>15</sup> Representative Bobby Rush (D-Ill.) and Senator Max Baucus (D-MT) have both publicly supported Grassley’s initiatives. Senator Baucus co-wrote the letter sent to Treasury Secretary Paulson regarding reforms to Form 990 and accompanying schedules. See Press Release, Senator Chuck Grassley, Sen. Grassley Works to Build Confidence in Nonprofits With Greater Transparency (May 29, 2007). Rush, initially outraged by the practice of “patient dumping,” has joined Grassley in legislative reforms to keep tax-exempt hospitals accountable under § 501(c)(3). See Jay Heflin, Politics Makes Strange Bedfellows in Fight Against Nonprofit Hospitals, <http://thehill.com/homenews/house/89541-politics-makes-strange-bedfellows-in-fight-against-nonprofit-hospitals> (last visited June 9, 2010). However, both Rush and Baucus voted for PPACA.

<sup>16</sup> Prior legislative efforts to reform tax exemption standards for hospitals had failed; for example, the Tax Exempt Hospitals Responsibility Act of 2006 introduced by Representative Bill Thomas (R-CA). See Helvin, *supra*, at 449-50.

<sup>17</sup> For an in-depth analysis of the cases, see Helvin, *supra*, at 433-40 (2008).

<sup>18</sup> Plaintiffs are not foreclosed from bringing claims under various state law statutes more protective of patients’ rights. However, such claims have not been entirely successful. See, e.g., *Galvan v. Nw. Mem’l Hosp.*, 888 N.E.2d 529 (Ill. App. Ct. 2008). More research would be helpful to (1) examine how different state courts have interpreted their state statutes, and in what states such claims are more successful than in others; and (2) whether discriminatory pricing schemes may have a disparate impact on any protected class.

<sup>19</sup> This case has never been cited by any federal court.

<sup>20</sup> Steven T. Miller, Commissioner of the Tax Exempt and Government Entities Division of the IRS, commented in a 2009 speech that “[m]ore than a dozen states have adopted written standards involving community benefit.” Steven T. Miller, Comm’r, Tax Exempt and Gov’t Entities, Internal Revenue Serv., Charitable Hospitals: Modern Trends, Obligations and Challenges (Jan. 12, 2009).

<sup>21</sup> To date, Tex. Health & Safety Code Ann. § 311.045 has not been cited in any state or federal case law.

reasonable in relation to the community needs, as determined through the community needs assessment, the available resources of the hospital or hospital system, and the tax-exempt benefits received by the hospital or hospital system;<sup>22</sup> (2) “in an amount equal to at least 100 percent of the hospital’s or hospital system’s tax-exempt benefits, excluding federal income tax;” or (3) by demonstrating that “charity care and community benefits are provided in a combined amount equal to at least five percent of the hospital’s or hospital system’s net patient revenue, provided that charity care and government-sponsored indigent health care are provided in an amount equal to at least four percent of net patient revenue.”<sup>23</sup>

These examples of statutory provisions and case law decisions are indicative of the legal trends at the state level to quantify specific charity care requirements for local tax-exempt status.

### From the Field: Billing and Collections by a For-Profit Hospital System

HCA is the largest private operator of health care facilities in the world and serves as a leader in the health care industry. HCA’s pricing, billing and collection practices can serve as an example for the nonprofit hospital industry. In June 2004, HCA CEO Jack Bovender, Jr. addressed the House Energy and Commerce Committee

Subcommittee on Oversight and Investigations to discuss hospital billing and collection practices. Although HCA employed a pricing scheme that charged uninsured patients more than insured patients, Bovender criticized the practice, noting “the chargemaster system on which hospitals rely to set pricing and billing codes has a forty-year history of changes that has distorted the relationship between price and cost.”<sup>24</sup> He went on to say that “HCA is now seeking to develop a pricing structure for the uninsured that is more reflective of the actual cost of providing the care.” *Id.* (emphasis added).

In 2007, HCA increased the transparency of its pricing structure by introducing the Patient Financial Resource, a pricing transparency initiative employed at HCA’s several hospitals that provides a “pricing estimate for [its] most frequently used healthcare services, payment options and alternatives available to patients without healthcare coverage and contact information to call [HCA] directly for a pricing estimate.”<sup>25</sup> This initiative paralleled the efforts of Senator Grassley at the federal level to increase the transparency of tax-exempt hospitals’ pricing schemes.

### Conclusion

Determining whether a charitable hospital’s billing and collection scheme violates federal law is fact-sensitive and depends upon several factors, including the status of the patient

under the financial assistance policy and the type of medical service rendered. It is clear from PPACA that patients must be informed of the existence of the hospital’s financial assistance policy and that qualified patients may qualify for free or discounted medical services. Not only must hospitals comply with PPACA by making “reasonable efforts” to determine if patients qualify for financial assistance before pursuing “extraordinary collection actions,” the amount hospitals may charge qualified patients for emergency or medically necessary care is limited. Discriminatory pricing schemes may also jeopardize a hospital’s tax-exempt status if the government determines that the hospital has failed to satisfy its charitable mission under the “community benefit” standard set forth in Revenue Ruling 69-545.

The trend toward price transparency efforts, led in part by HCA, may help further ensure not only that uninsured and underinsured patients are not unfairly charged by tax-exempt hospitals, but that hospitals receive fair revenue for medical services necessary to allow the hospitals to continue to operate in a manner that benefits the community.

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<sup>22</sup> See Tex. Health & Safety Code Ann. § 311.045 (c) (Vernon 2010) provides “guidelines” for the hospital in determining the amount of care required. Community needs, available hospital resources, tax-exempt benefits received, and other factors unique to the hospital, are among the factors to be considered.

<sup>23</sup> Tex. Health & Safety Code Ann. § 311.045 (b)(1)(A)-(C) (Vernon 2010).

<sup>24</sup> A Review of Hospital Billing and Collection Practices: Hearing Before the H. Energy & Commerce Comm. Subcomm. on Oversight and Investigations, 108th Cong. 4 (2004) (statement of Jack Bovender, CEO of HCA).

<sup>25</sup> HCA, Welcome to the Patient Financial Resource, <http://www.hcahealthcare.com/CustomPage.asp?guidCustomContentID={C7403AAF-2EFC-4CC9-BEC9-3D5815D11C45}> (last visited June 16, 2010).

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## CMS Proposes Streamlined Approach for Credentialing of Telemedicine Providers

by Victoria Heller Johnson



On May 26, 2010, the Centers for Medicare and Medicaid Services (CMS) issued a proposed rule that would ease the burden for Medicare-participating hospitals and critical access hospitals (CAHs) when it comes to credentialing and privileging off-

site telemedicine providers. The proposed rule would revise the existing Medicare conditions of participation (CoPs) for both hospitals and CAHs to allow for a new streamlined credentialing and privileging process for physicians and practitioners providing telemedicine services.

The current CoPs require Medicare-participating hospitals and CAHs to

credential and privilege each physician and practitioner providing telemedicine services from a distant site as if such physician/practitioner were onsite. While hospitals and CAHs are permitted to use third-party credentialing verification organizations, the ultimate responsibility for privileging decisions remains with the facility’s governing body.

## Staying Well Within the Law

In the past, hospitals accredited by The Joint Commission (TJC) were deemed to meet the Medicare CoPs under TJC's statutory deeming authority. TJC's medical staff standards permit privileging by proxy whereby a TJC-accredited originating site (i.e., the site where the patient is located) may accept the credentialing and privileging decisions of a TJC-accredited distant site (i.e., the site where the practitioner providing the telemedicine service is located). Pursuant to Section 125 of the Medicare Improvements for Patients and Providers Act of 2008 (Public Law 110-275, July 15, 2008), the statutory recognition of TJC's hospital accreditation program was terminated effective July 15, 2010. As a result, TJC-accredited hospitals that have used privileging by proxy to credential and privilege their telemedicine providers up to this point may no longer do so.

CMS recognized in the proposed rule the significant burden that would be placed on existing telemedicine programs, particularly those of small or rural hospitals and CAHs that are TJC accredited, if privileging by proxy is no longer permitted. Such institutions often lack the resources to carry out the traditional credentialing and privileging process for the physicians and practitioners who provide telemedicine services and rely on the larger academic medical centers that provide such practitioners to fulfill that function.

The proposed revisions affect two Medicare hospital CoPs – 42 C.F.R. § 482.12 “Governing Body” and 42 C.F.R. § 482.22

“Medical Staff.” Under the proposed rule, CMS would add new paragraph § 482.12(a)(8) that would allow a hospital's governing body to grant telemedicine privileges based on its medical staff recommendations, which in turn would rely on information provided by the distant-site hospital. Under this new provision, the agreement between the hospital and the distant site must specify it is the responsibility of the governing body of the distant site to meet the requirements of paragraphs (a)(1) through (a)(7) of § 482.12 with regard to its physicians and practitioners providing telemedicine services.

The proposed rule would also add § 482.22(a)(3), which grants a hospital receiving telemedicine services the option to rely on the credentialing and privileging decisions of the distant site in lieu of the current requirements at §§ 482.22(a)(1) and (a)(2), which require the hospital's medical staff to conduct individual appraisals and examine the credentials of each candidate in order to make a privileging recommendation to the governing body. In order to avail itself of this option, the hospital receiving the telemedicine services must ensure that:

- (1) The distant site hospital is a Medicare-participating hospital.
- (2) The individual distant-site physician or practitioner is privileged at the distant-site hospital providing the telemedicine services, which provides a current list of the distant-site physician's or practitioner's privileges.

- (3) The individual distant-site physician or practitioner holds a license issued or recognized by the state in which the hospital, whose patients are receiving the telemedicine services, is located.
- (4) With respect to a distant-site physician or practitioner granted privileges, the hospital whose patients are receiving the telemedicine services has evidence of an internal review of the distant-site physician's or practitioner's performance of these privileges and sends the distant-site hospital such performance information for use in the periodic appraisal of the distant-site physician or practitioner. At a minimum, this information must include all adverse events that result from the telemedicine services provided by the distant-site physician or practitioner to the hospital's patients and all complaints the hospital has received about the distant-site physician or practitioner.

The proposed telemedicine privileging and credentialing requirements for CAHs are virtually the same with almost no differences in the regulatory language.

CMS will accept comments on the proposed rule until July 26, 2010.

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