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Health Headlines

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IRS Releases Community Health Needs Assessment Guidance for Tax-Exempt Hospitals – On July 7, 2011, the Internal Revenue Service (IRS) released Notice 2011-52 (the Notice), a 28-page document that provides guidance to tax-exempt hospital organizations regarding Internal Revenue Code Section 501(r)(3)'s community health needs assessment (CHNA) requirements. The Notice describes specific provisions related to the CHNA requirements that the Treasury Department (Treasury) and the IRS anticipate will be included in regulations to be proposed under Section 501(r). The Notice also solicits comments on these provisions. Comments must be submitted by September 23, 2011.

Section 501(r)(3) was added to the Internal Revenue Code by the Patient Protection and Affordable Care Act (PPACA). Among other requirements, Section 501(r)(3) requires tax-exempt hospital organizations to conduct a CHNA every three years and adopt implementation strategies to meet the needs identified in the CHNA. If a hospital organization operates more than one hospital facility, it must satisfy the CHNA requirements separately with respect to each. Hospital organizations may be subject to a $50,000 excise tax per hospital facility for each year in which it fails to satisfy the CHNA requirements with respect to that facility.

Although the CHNA requirements are not effective until taxable years beginning after March 23, 2012, Treasury and the IRS published the Notice in advance of the proposed regulations in order to provide guidance to hospital organizations that choose to begin the process of conducting CHNAs and developing implementation strategies in advance of the effective date. A hospital organization may rely on the anticipated regulatory provisions described in the Notice with respect to any CHNA the hospital organization makes widely available to the public and any implementation strategy adopted by the hospital organization on or before the date that is six months after the date further guidance regarding the CHNA requirements is issued.

The Notice contains information relating to many specific aspects of Section 501(r)(3)'s CHNA requirements, including discussions of the following topics: information that must be included in each written report documenting a CHNA, the requirement that a CHNA "take into account input from persons who represent the broad interests of the community served by the hospital facility," how a CHNA may "be made widely available to the public" as required by the law, adoption of an implementation strategy to meet the community health needs identified through the CHNA, and reporting requirements related to CHNAs.

IRS Notice 2011-52 is available by clicking **here**.

Reporter, *Catherine S. Stern*, Atlanta, +1 404 572 4661, kstern@kslaw.com.

California Department Of Insurance Issues Order to Show Cause Against Blue Shield of California for Denying Autism Treatments – On July 13, the California Department of Insurance (CDI) announced its issuance of a Show Cause

Order and commencement of an enforcement action against Blue Shield of California Life and Health Insurance Company (Blue Shield) for failing to comply with the California Mental Health Parity Act (MHPA) and the California Insurance Code. At issue is Blue Shield's denial of coverage for autism treatments known as Applied Behavior Analysis (ABA) therapy.

The MHPA requires coverage for the diagnosis and medically necessary treatment of "severe mental illnesses" which the Act defines to include "[p]ervasive developmental disorder or autism." The CDI enforcement action arises from complaints filed by the parents of two children diagnosed with autism. The children's treating physicians prescribed ABA therapy. Blue Shield denied coverage for the therapy, claiming that the treatments are medically unnecessary, experimental, not administered by a licensed provider, and a therapy for non-covered learning disabilities and social skills training.

The parents sought an Independent Medical Review (IMR) through the CDI. The IMR procedure allows California citizens to obtain an independent physician's review and determination of whether a disputed health care service is medically necessary. The IMR ruled the ABA therapy medically necessary for the treatment of autism for both children, and the CDI adopted the IMR decisions. The CDI then ordered Blue Shield to provide coverage for the medical services, but Blue Shield refused for the same reasons given initially.

The Order to Show Cause alleges claims for unfair competition and deceptive practices in violation of the California Insurance Code and violations of the MHPA. The Order requires Blue Shield to appear before the Commissioner of Insurance on a date to be determined and seeks a cease and desist order against Blue Shield, monetary penalties, and suspension of its certificate of authority not to exceed one year. A copy of the Order is available by clicking **here**.

Reporter, *Jesica M. Eames*, Atlanta, +1 404 572 2821, jeames@kslaw.com.

CMS Releases Revised Advance Beneficiary Notice of Noncoverage (ABN) Form for Medicare FFS Providers; Mandates Use by November 1, 2011 – On June 20, 2011, the Centers for Medicare and Medicaid Services (CMS) released a newly-revised version of the Advance Beneficiary Notice of Noncoverage (ABN) form [CMS-R-131] for use by Medicare fee-for-service providers and suppliers.

The ABN is a notice that is given to Medicare beneficiaries by providers and suppliers to convey that Medicare is not likely to provide coverage for proposed services, thus the beneficiary or another payor will be liable for payment if the services are rendered by the provider. The ABN must be verbally reviewed with the beneficiary or his/her representative, and questions raised during that review must be answered before it is signed. The ABN must be delivered to the beneficiary far enough in advance of the noncovered services to allow the beneficiary to consider alternatives and to make an informed choice.

The new ABN form replaces the General Use ABN [CMS-R-131-G] and the Lab ABN [CMS-R-131-L]. The CMS Beneficiary Notices Initiative website indicates that providers may use the previous versions of the ABN forms until November 1, 2011. After this date, CMS will no longer recognize providers' use of the older ABN forms, which were released in March 2008.

For more information from CMS regarding the newly revised ABN, click **here**. For detailed instructions in the Medicare Claims Processing Manual regarding the completion of an ABN form, click **here**.

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House Bill Would Change EHR Incentive Payment Methodology for Multi-Campus Hospitals – On July 12, a bipartisan group of members of the U.S. House of Representatives introduced the "Equal Access and Parity for Multi-Campus Hospitals Act," which would revise the methodology used to make Medicare and Medicaid EHR Incentive payments to hospitals with multiple campuses all operating under the same CMS Certification Number (CCN). Currently, all inpatient facilities that operate under the same CCN are treated as a single eligible hospital. While the bill would not treat each inpatient campus as an eligible hospital for purposes of receiving incentive payments under the HITECH Act,

the proposal would offer a multi-campus hospital the choice of having either its base payment amount or discharge-related payment amount re-calculated to reflect multiple inpatient facilities.

Under current law, all eligible hospitals that demonstrate meaningful use of certified EHR technology may receive a Medicare and Medicaid incentive payment equal to a base amount – $2 million – plus a per-discharge add-on payment, multiplied by the hospital's share of Medicare or Medicaid patients. The bill would give a multi-campus hospital the option to have its $2 million annual base payment amount or its annual discharge related amount (but not both) increased based on the number of its inpatient facilities that themselves qualify for meaningful use. Hospitals must submit an attestation that every facility – the main provider and all remote inpatient locations – qualifies as a meaningful user. A hospital's choice would apply for all prior and subsequent payment years.

To date, there has been no companion bill introduced in the Senate. Similar bills were introduced in both chambers during the last Congress. The text of the current House bill is available by clicking **here**.

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