Bama Chatter

HFMA ALABAMA CHAPTER

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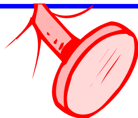

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Chairman's Theme "Leading at the Speed of Light"

Ronald R. Long, FHFMA, CPA, Chairman of HFMA's Board of Directors for 2001-02 has selected "Leading @ the Speed of Light" as the theme for 2001-02.

Today's healthcare industry is changing and new technologies are being introduced almost daily. Financing mechanisms are changing almost as rapidly. The healthcare financial leader is being challenged as never before to understand trends and solve problems in a creative fashion as well as make decisions quickly. The risk of poor investments or not making investments, particularly in the area of technology, has increased dramatically. In order to cope with these challenges, the healthcare financial leader must develop new skills and become educated as never before. HFMA is in a unique position to provide leaders with the education and skill development necessary to prosper in this new environment. In order to accomplish this, HFMA itself must aggressively adopt technologies which will allow it to deliver education in a timely and efficient manner, while lowering the overall cost to it's members in both time and dollars.

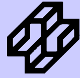
In order to be an effective leader in today's environment creative thinking must be employed. Technology alone will not solve problems without leaders applying the technology in a creative manner, thereby creating value for their organizations.

In order to "Lead @ the Speed of Light" leaders must understand not only financing trends, but trends in new technology. This allows the leader to position the organization for success over the long term Thinking strategically with a long term focus on technology trends is a key skill required by financial leaders today.

The member's need to receive education in a more efficient and effective manner must be HFMA's top priority. In addition, the content of education must be timely and targeted to new developments in order to give our members the edge they need to succeed.

"Leading @ the Speed of Light" is more than just a catchy saying, it is a style of leading which has become essential to success in today's fast paced environment.

Leading @ the speed of light



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Quarter page: $100 per issue—Half page: $175 per issue—Full page: $300 per issue
Special discounts for long-term arrangements. Contact the editor for details.

Please send your ad and graphics on plain white paper or slicks. Deadline for publication is the 20th of the month preceding the month of publication. *Bama Chatter* is published bimonthly and is circulated to approximately 700 recipients.

Publication Schedule

ISSUE	DEADLINE	ISSUE	DEADLINE
September/October	August 20th	March/April	February 20th
November/December	October 20th	May/June	April 20th
January/February	December 20th	July/August	June 20th

The statements and opinions appearing in articles are those of the authors and are not necessarily those of HFMA, the Alabama Chapter, or the editor. The editor strongly encourages submission of material for publication. Articles should be typewritten and double spaced, and submitted to the editor or the awards council chairperson by the 20th of the month preceding the month of publication. The editor reserves the right to edit materials and accept or reject contributions whether solicited or not. Readers are invited to comment on any of the published material. Letters to the editor must be signed and are subject to condensation and editing. All rights reserved.

Don't Just Complain, Be Heard in Washington!

The American Hospital Association is holding its annual meeting in Washington, D.C. April 28th - May 1, 2001. Paul Graham and I will attend the meeting as representatives of the Alabama Chapter of HFMA. On the final day of the meeting, the Alabama delegation will spend the day meeting with each of our Representatives in the House and our two Senators. It is important that we make our issues known in Washington and the best way to do that is to write your Congressmen and Senators.

The clear, consistent message we heard last year from our Congressional Delegation was that our message of concern was not being heard in Washington. Unless our representatives in Washington hear our concerns, no changes will be made and no significant legislation will be passed regarding our issues. Take the time to write a letter and make sure that our message is heard.

For your convenience, our Congressmen and Senators are listed below. Please contact Paul or myself if there is a specific issue that you would like for us to take to the meetings.

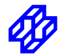
This HFMA Chapter year is quickly coming to an end, but member enthusiasm and energy are still going strong! There are four more meetings scheduled for this Chapter year:

- The Region V Dixie Institute hosted by the Tennessee Chapter in Gatlinburg, Tennessee;
- King & Spalding Southeastern Health Law & Policy Forum meeting in Atlanta, Georgia;
- CFO Forum on APCs in Birmingham; and
- Annual Institute in Sandestin, Florida.

The dates and specific locations are on the calendar. Mark your calendars and make plans to attend now. These meetings have a great line up of speakers and topics that will be of interest to you.

The HFMA Southern and Winter Institutes were both great successes. HFMA congratulations go to Nancy Strachan and Sydney Rountree, respectively, for hosting such successful and fun meetings! Thanks for all the hard work!

Remember the next CHFP exam on March 9, 2001. Encourage your staff to become certified - it is a designation that shows leadership in your field. Also, remember to check out our web site at www.alhfma.org. Our Chapter web site can be an invaluable resource for Members - don't forget to utilize it. I look forward to seeing you at the upcoming HFMA meetings!

Annette 

Annette N. Baker, FHFMA
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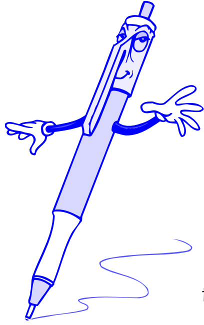
From the Editor's Desk . . .



One of the few things all Americans have in common is a dreaded sense of the IRS and taxes. Many have termed it the "Infernal" Revenue Service. Webster's defined "infernal" as hellish, diabolic and damnable - I think most would find this definition appropriate given their fear of the IRS. But like it or not the clock is ticking away - only few days left to file your 2000 tax return. Here are some interesting facts and fun tidbits about our common problem that may make filing your taxes a little easier.

Dawn Walton, CPA, Chairperson Publications Committee

The IRS and You

Filing Returns

- Over 50% of us file our federal income tax return before April1 of each year.
- Most of the rest file in the first two weeks of April.
- 5% get an extension to August 15.
- 1% extend further to October 15.
- According to the IRS, at least 3% of us don't file at all.

Audits and Appeals

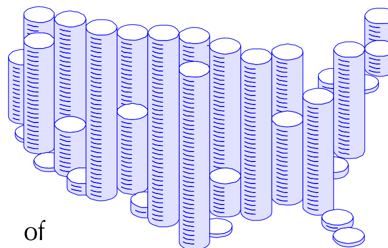
- We call them audits; the IRS prefers "examinations".
- Whatever, you tem it, it is the most dreaded experience of a taxpayer.
- Your chance of being audited in any one year is only about 1%.
- The odds of an IRS examination in your taxpaying lifetime are closer to 50%.

Tax Bills

- Virtually every taxpayer faces, at one time or another, a tax bill he cannot pay.
- The bill may come in response to a return you've filed, after an audit, or out of the blue years after the tax year in question.
- At any given time 15% of all taxpayers owe back taxes.

Cheating, Fraud & Other Tax Crimes

- It shouldn't come as a shock, but it is a crime to cheat on your taxes.
- In a recent year, however, only 2,472 Americans were convicted of tax crimes — .0022% of all taxpayers.
- The IRS estimates 17% of all taxpayers are not complying with the law in one way or another.
- According to the IRS, individual taxpayers do 75% of the cheating - mostly middle-income earners.



- Most common form of cheating - underreporting of income. A government study found the bulk of underreporting was done by self-employed restaurateurs, clothing storeowners and -this will shock you - car dealers. Telemarketers and salespeople came in next, followed by doctors, lawyers (heavens!), accountants (good heavens!) and hairdressers.
- The IRS has concluded that only 6.8% of deductions are overstated or just plain phony.
- A careless mistake may cost you a 20% penalty on your tax bill. The cost of tax fraud - a 75% civil penalty and could mean a criminal investigation.

Rules of the Game — Tax Laws

- The Internal Revenue Code is amended every year.
- It is over 4,500 pages long.
- Many tax laws are passed for purposes other than raising money.
- Many special interest groups have gotten laws passed that are designed to give them special treatment. These special provisions outnumber the laws of general application.
- Americans have the dubious honor of having the most complex income tax laws in the world.
- Blame Congress - it is easier to pass a tax law than to administer it.

Information courtesy of Nolo - Law for All, putting the law into plain English! Log onto www.nolo.com for related articles and more tips and information about these and hundreds of other law subjects.

Congratulations CPAR Participants

There were a total of 81 applicants who tested for the November 2000 CPAR exam. The PFS Forum is proud to announce that 69 were successful in passing the exam. That 's an 85% passing rate.

WOW!! Congratulations on a job well done!

CPAR Coaching & Testing

Who Is The Program For?

Any Business Office associate not already certified.

Coaching Sessions

Four locations have been designated for Coaching Sessions. Dates and locations are as follows:

APRIL 21 & 28, 2001

- **Birmingham at Baptist Medical Center, Montclair**

(space will be limited to the first 60 registrants per session)

- **Guntersville at Marshall Medical Center North**
- **Fairhope at Thomas Hospital**
- **Dothan at Southeast Alabama Hospital**

Test Date

The test will be given on **May 5, 2001** at:

- **Birmingham at Eastern Health System**
- **Guntersville at Marshall Medical Center North**
- **Fairhope at Thomas Hospital**
- **Dothan at Southeast Alabama Hospital**

How Do I Register?

Contact one of the following to register or with questions.

Nancy Strachan, *Fairhope*
(334) 990-1550
Linda Maddox, *Birmingham*
(205) 592-5859
JoAnn Hudspeth, *Guntersville*
(256) 571-8039
Pam Sanders, *Fairhope*
(334) 990-1551
Miriam Hubbard, *Dothan*
(334) 793-8827

The Trainers for Baptist Health System and Ascension, Patricia Donaldson and Wanda Shorter, are revising the CPAR Manual. The revised manual may not be available until the Fall Session.

NEW MEMBERS

Susan C. Angelo*
Computer Associates International, Inc.

Diane S. Davis*
HealthSouth Rehabilitation Hospital of Montgomery

L. Stephan Vincze, J.D.*
Vincze & Frazer

**Please call us with your sponsor's name.*

Member Get A Member Sponsor Standing

SPONSOR	TOTAL RECRUITED
TOTAL WITH NO SPONSOR LISTED	19
Joel T. Barnett, CPA	1
Robert P. Levesque, FHFMA	1
Kathy B. Nelson, Marshall Medical Center South	1
Catherine G. Norwood, Marshall Medical Center So.	2
Yolanda D. Rich, Baptist Health System	2
Vicki L. Winters	1
TOTAL RECRUITED FOR 2000/2001	**27**

To receive applications for new members or additional information, please call Pollyanna Brannan at 1-800-264-2700 ext. 213. If she is away, please leave your name, number, address and fax on the voice mail and she will respond ASAP!

Member-Get-A-Member Contest Update

Let's get busy and recruit — the year is winding down and the 3 DAY/2 NIGHT STAY AT SANDESTIN is still available to be won. Catherine Norwood of Marshall Medical Center South and Yolanda Rich at Baptist Health System are currently tied for TOP RECRUITER, but you still have time to jump into the lead.

Be on the lookout for prospective members and share HFMA! Thanks to all those participating.

APCs . . . The Aftermath

Presented by the CFO Forum

March 22, 2001 · 8:00 am - 5:00 pm

Embassy Suites · Birmingham, Alabama

This is the seminar that you've all been waiting for! Cynthia (Cindy) Dupree with Draffin & Tucker, LLP, will be returning to present this follow-up seminar from May 2000. Many of those attending last year's session remarked on how very interesting it was and how much it enabled participants to leave the meeting being able to apply the new knowledge!

Are You Leaving $$$$$ On The Table?

Topics will include:

- Are You Leaving $$$$$ On The Table?
- Are You Billing Everything You Are Entitled To?
- Are Your HCPCS and CPT codes correct?
- Are Your Remittances Correct?
- What To Look For When Reviewing Claims and Payments

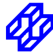
Who Would Benefit?

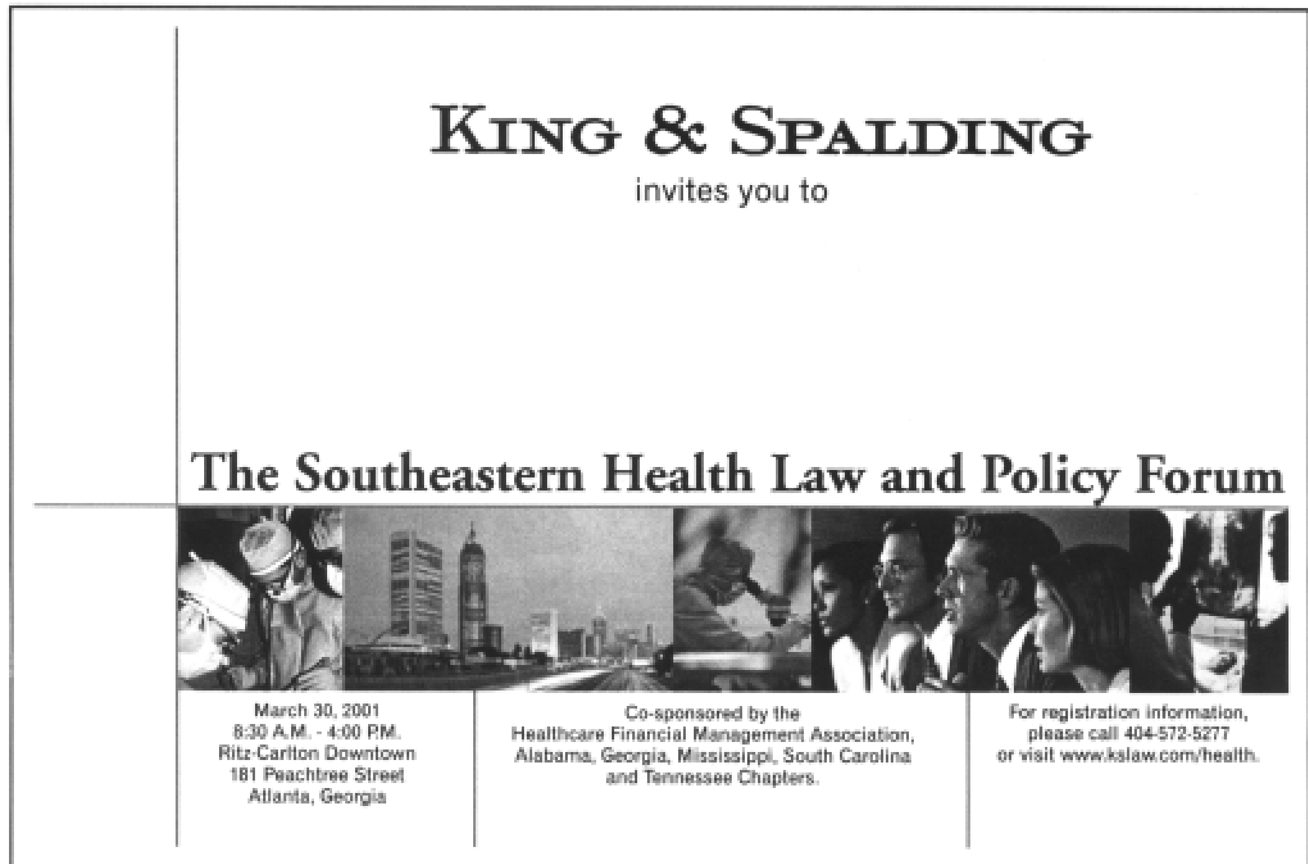
CFOs, Outpatient Coders, Finance Staff, Charge Master Coordinators, Billing Staff - anyone involved in the billing cycle or reimbursement of an outpatient facility. The morning session will be very educational for everyone. The afternoon session will feature a coding workshop especially geared toward billers and coders.

Breakout sessions will be held for actual "hands on" application of seminar material. Also, we are applying to the State Board of Accountancy to have this qualify for CPEs and for CCS, RHIA and RHITs certification.

Please Note:

This seminar is limited to 70 registrants. Registration brochures to be mailed soon, or if you need additional information call Libby Bailey at (205) 325-8525.





National HFMA Working For You

HIPAA

Of critical importance in 2001 are the electronic transaction standards, privacy, and security provisions of the Health Insurance Portability and Accountability Act of 1996. Throughout 2000, HFMA's HIPAA advisory group grew in diversity and broadened expertise, and now includes members who are helping the federal agencies write HIPAA's rules and standards. This group of volunteer experts is working with HFMA to develop effective programs and tools to help members understand and implement HIPAA. Materials include educational programs, on-line learning modules, articles and web-based tools and reference materials.

BIPA Implementation

Providers in 2001 will enjoy higher Medicare payments for most services, thanks to the Medicare, Medicaid, and SCHIP Benefits Improvements and Protection Act (BIPA), which became law December 21, 2000. HFMA worked toward the law's enactment by cosponsoring the Coalition to Protect America's Healthcare, a group of 100 hospitals, major associations, and businesses that worked to develop broad-based support for restoration of Medicare funding cuts. HFMA provided financial, technical, and communications support to the coalition.

Patient-Friendly Billing Project

In 2000, with the support of the AHA and other stakeholders, HFMA initiated a project to identify barriers to, and best practices for, providing clear, concise, and correct billing information to patients. The project currently is in its first phase. On October 3, representatives from HCFA, major providers, auditing and consulting firms, and other essential stakeholders met and outlined major facets of the project. These facets include regulatory and legal barriers, patient and consumer communications, the process and revenue cycle, information technology, and state issues. After gathering input from patient and customer focus groups, a tack force will draft a working paper for review and comment by the entire advisory panel. The final paper is scheduled to be disseminated in October 2001 through HFMA, AHA and sponsoring organizations. Corresponding educational programs will be developed. The second phase of the project will focus on medical practice and payer financial communications.

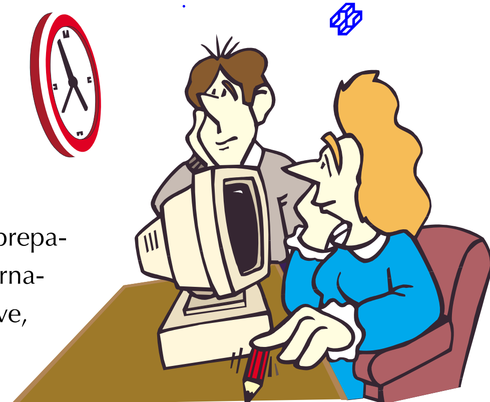
Reserve Cost Reports

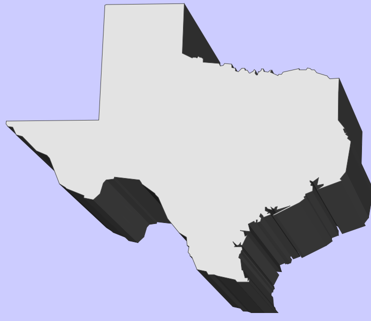
Accountants and auditors are carefully watching a Department of Justice lawsuit that accuses a firm of playing a role in submitting fraudulent Medicare and Medicaid hospital cost reports. At issue is whether the preparation of reserve cost reports means that the submitted cost report is incorrect or fraudulent. In an earlier fraud lawsuit against hospitals then owned by Columbia/HCA, HFMA filed an amicus brief asserting that the existence of cost reports other than those submitted is not evidence of fraud. Generally accepted accounting principles sometimes require providers to estimate the effects of potential adjustments. This is done through the preparation of alternative, or reserve, cost reports.

Financial Disclosure

HFMA continues to advocate for appropriate disclosure of financial information. During the first annual Non-Profit Healthcare Conference, cosponsored in May 2000 by HFMA, HFMA President and CEO Richard Clarke, FHFMA, emphasized that in today's dynamic environment, healthcare organizations have an obligation to disclose useful and timely financial and operational information to their many stakeholders. HFMA has long advocated appropriate disclosure, and HFMA's Principles and Practices Board's Statement 18, "Public Disclosure of Financial and Operating Information by Healthcare Providers, " is cited by the SEC as "market practice" for disclosure for the healthcare industry.

For more details on these and other Healthcare topics, visit the HFMA web site (www.hfma.org).





Make Plans to Attend The

Annual National Institute

June 17 - 21, 2001
Marriott River Center
& Henry B. Gonzalez Convention Center
San Antonio, Texas

- **The latest and greatest information on the hottest topics in healthcare financial management**
- **As many networking opportunities as possible**
- **Premier Keynote speakers**
- **Excellent opportunities to listen, learn and interact with healthcare financial experts**
- **Activities that allow you to mix business with pleasure!**

Are Standardized Medical Records A Benefit?

Will the mandated standardization of medical records by HIPAA really benefit patients?

by Keith Rasmussen, Healthcare Guide
About.com

What is touted to save $73 billion a year, bring access to the patient and is mandated by 2002? You guessed it: e-based uniform medical records. The push is on to digitize medical records even as issues of security and privacy heat up. Of course, the drive to develop secure records does not anticipate the biggest threat to confidential records: the patient.

What good will laws and computer security features do if the patient is put into the position of releasing the records? Take health insurance as an example. To obtain coverage, the applicant is required to sign a release for medical records to the insurer. Most large companies are self-insured which means the employer in essence obtains the records. This is exactly what privacy advocates are trying to prevent. Yet little is being said about protecting the patient from this situation.

An issue facing providers is that the Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires hospitals and other originators of individual medical data to certify that any business that they shared data with comply with the security and privacy regulations. How will originators certify that the myriad of possible third party companies comply? For an example of this problem, take a hospital in Los Angles that accepts a patient for emergency treatment who is a resident of Clearwater Florida whose insurance is administered by a small third-party administration firm there? Multiply this example by thirty different patients a day and you have a tremendous data collection issue.

Another area of concern for privacy advocates is the broad wording in the regulations. The act states that organizations can use patient information "...for treatment, for payment, and related operations and for additional purposes that are in the public interest...". The "public interest" clause can by widely interpreted by employers, researchers, federal, state and local governments, and law enforcement agencies.

The value of any regulation is only as great as the power of the enforcement. What can an individual do if they feel their records have been too freely disseminated? For the individual there is no right to sue for breach of the regulations. Ultimately, encryption technology is capable of protecting the transmission of the data. The real risk lies within. How can health care organizations determine which employees can access the data? Too much access can permit unwanted release of client data, but a lack of sufficient medical history at the time of treatment could result in mis diagnosis or dangerous allergic reactions that could have been avoided. Organizations on the forefront of data integration use multiple levels of access for employees as well as tracking the users data retrieval. The day when all records are standardized is coming but the challenges are daunting. It remains to be seen if the change will really benefit the patient in the end.

HIPAA Privacy Standards Published

On December 20, 2000, HHS Secretary Donna E. Shalala released the long awaited final regulation on privacy standards under the Health Insurance Portability and Accountability Act (HIPAA) of 1996. The final regulation strengthens the security of medical records and extends coverage to include paper records, oral communications, and electronic information. The new standards apply to all consumers whether they are privately insured, uninsured or are covered under Medicare or Medicaid. Entities covered by the regulation are prohibited from using or disclosing protected health information except as stipulated in the final regulation.

The regulation requires providers to obtain a patient's consent for routine use and disclosure of health records, and requires the patients' authorization for non-routine disclosures. The regulation further requires providers to send only the minimum information needed (e.g., bills) for the purpose of the disclosure. For medical treatment, the regulation gives the providers full discretion in determining what personal health information to include when sending a patient's medical record to other providers. It also protects the patient against the unauthorized use of their medical records for employment purposes. Additionally, patients have the right to access their medical records and to know who else has accessed them. There are specific federal penalties associated with the regulation if a patient's rights are violated.

Secretary Shalala stated, "More federal legislation is needed in order to fortify the penalties and to create a private right of actions so that citizens can hold health plans and providers directly accountable for the inappropriate and harmful disclosures of information."

Additionally, the financial assessment on the overall cost for the privacy standards and the electronic claims regulation as purported by HHS, is estimated to be $17.6 billion over a 10-year period. HHS estimates that both of the regulations have a projected net savings of $12.3 billion for the healthcare system.

HFMA Conducts HIPAA Survey

HFMA recently conducted a survey assessing members' level of readiness for HIPAA implementation.

Summary Results

- Most respondents note a general understanding of HIPAA.
- Almost a third felt there was a lack of understanding within their organization.
- Over 40% have begun gap analysis and planning.
- More systems than hospitals have begun gap analysis; planning; and, in some cases, implementation.
- A hospital or system with 301-500 beds is more likely to have begun to address gaps and risks than either a 1-300 bed hospital/ system *or* one with over 500 beds.
- Small, rural hospitals are the least likely to have begun the implementation process.
- While many have started the process, several noted that they were waiting for the final rules to be published.

The Challenges

The most frequently noted challenges for the next six months include:

- Cost of implementation and planning appropriate budgets;
- Time and staffing constraints;
- Conforming with preceding laws;
- Focusing on the opportunities as well as compliance; and
- Involving the right people in the process. A related issue is developing buy-in with senior management and the board of directors that this needs to be an organization-wide priority.

Overall 47% of providers, systems, and payers have some assigned structure in place to oversee HIPAA.

WHERE ARE ORGANIZATIONS IN THE IMPLEMENTATION PROCESS?

Awareness	Understanding	Gap Analysis/Planning	Implementation
17% of respondents noted little or no awareness within their organization	92% of respondents have a general understanding of HIPAA. 32% feel there is a lack of understanding within their organization. Only 35% feel confident explaining HIPAA to others.	40% are uncertain about what to do first. 42% have begun inventory policies. 41% have begun to assess risk and impact. 49% of providers, systems, and payers have some defined structure.	17% of systems and 5% of hospitals have begun to address gaps and risks. 7% of systems and 3% of hospitals have begun implementing to ensure compliance.

Understanding How the Best Performers Manage A/R

by Charles Lund
Zimmerman & Associates

The Third-Quarter HARA Report (Hospital Accounts Receivable Analysis) reported national average gross days revenue outstanding at 63 - and further indicated that their best practice peer group "hospitals under 60 GDRO" actually averaged 45 GDRO.

In an attempt to understand the potential payer issues that differentiate average hospitals from the best facilities, we applied Zimmerman & Associates Best Practice Payer Class Specific GDRO Improvement Grid, (published in the January 2001 edition of Hospital Receivables Management), to the supporting statistical information supplied in the HARA Report and identified some interesting trends:

Self-Pay

Average Performers: 138 GDRO
Best Performers: 119 GDRO

Self-pay still doesn't represent a large percentage of the admitting financial class and therefore is underestimated as a revenue component. However, most receivables managers will now readily acknowledge that growing deductible and co-pay levels have created a significant collection challenge. Best practice facilities do a slightly better job collecting self-pay, but are still largely very timid about approaching the patient regarding their financial responsibility.

Change is in the wind - time of service collection programs represent one of the most requested areas of assistance - and the requests come from best practice and for-profit facilities.

Medicare

Average Performers: 36 GDRO
Best Performers: 26 GDRO

A difference of 10 days doesn't seem particularly significant - until you factor in that Medicare represents 35 to 45 percent of most hospitals revenue. Revenue cycle management "101" says - submit a clean Medicare claim and its money in the bank 14 days later. Best performers focus on this payer - particularly as it relates to minimizing medical record delays.

Blue Cross

Average Performers: 59 GDRO
Best Performers: 44 GDRO

Blue Cross plans - particularly for outpatient services - have become very challenging in many regions. Procedure based documentation requirements in some of their plans have all but eliminated the advantages of this highly electronic payer. But better performers focus on submitting a clean claim and are able to reduce payment delays by 25%.

Commercial

Average Performers: 85 GDRO
Best Performers: 73 GDRO

We were candidly surprised that better performers had 73 days revenue tied up in commercial insurance claims. Having said that, our suspicion is that most of the dollars represent self-pay after insurance that has simply not been re-classified to the appropriate financial class. Many hospitals are guilty of this practice, which can result in an over-valuation of the collectability of accounts.

There is no reason commercial dollars should age over 60 days. If they do, there are very likely systemic problems that need to be addressed.

Medicaid

Average Performers: 63 GDRO
Best Performers: 52 GDRO

Medicaid delays are often related to external factors - approval processes, either at the state agency or at the outsourced service bureau. To further complicate comparisons, there are also different ways to classify this number (generally accepted practice calls for classifying "Medicaid Pending Approval" as self-pay rather than Medicaid).

Best performers generally employ an incentive based application service bureau - who get paid only if the application is approved and only if the hospital receives payment. This keeps the process tight and involves them in the complete reimbursement cycle.

HMO

Average Performers: 66 GDRO
Best Performers: 45 GDRO

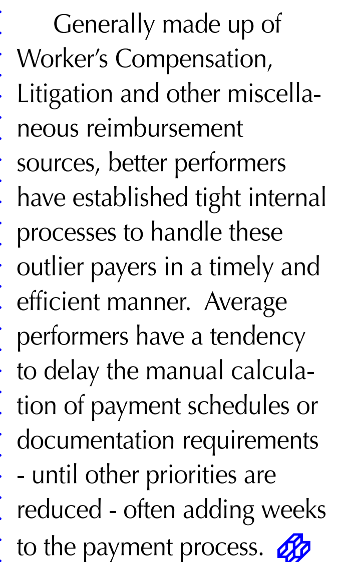
This financial class continues to grow in importance to overall cash flow - and it represents significant follow-up challenges.

Best performers analyze ALL aspects of the reimbursement cycle for managed care payers and hold them to the terms of their contract, which has resulted in a 30 percent reduction in cash flow delays.

Other

Average Performers: 98 GDRO
Best Performers: 66 GDRO

Generally made up of Worker's Compensation, Litigation and other miscellaneous reimbursement sources, better performers have established tight internal processes to handle these outlier payers in a timely and efficient manner. Average performers have a tendency to delay the manual calculation of payment schedules or documentation requirements - until other priorities are reduced - often adding weeks to the payment process.



Chuck Lund is chief executive officer of Zimmerman & Associates. This article is reprinted from the Hospital Receivables Management newsletter published by Zimmerman & Associates. For a FREE copy of this newsletter, call 800-525-0133 or e-mail your request to christy@zimm-assoc.com or fax 414-425-4807.

Stark II – Final Rules Issued

by William Whatley
Health Group of Alabama

In 1989, the Omnibus Budget Reconciliation Act of 1989 (OBRA 1989) added Section 1877 to the Social Security Act. Section 1877 prohibited a physician, under certain circumstances, from referring a patient to an entity for clinical laboratory services for which Medicare might pay. The prohibition was effective if the physician or a physician's immediate family member had a financial relationship with the entity. The statute defined a "financial relationship" as an ownership or investment interest in the entity, or a compensation arrangement between the physician (or the physician's immediate family) and the entity receiving the referral.

The statute also prohibited the servicing entity involved in the prohibited referral from rendering a claim or bill to Medicare, an individual, a third party payer, or any other entity. Provisions of the statute also required the refunding of any amounts collected. In addition, reporting requirements were established and sanctions, such as civil monetary penalty provisions, were provided under the statute.

Several laws subsequently enacted have amended or modified Section 1877 of the Act. OBRA 1990 clarified definitions and reporting requirements. OBRA 1993 expanded the referral prohibition to cover 10 designated health services, in addition to clinical laboratory services. The law also modified some of the existing statutory exceptions and added new exceptions. Changes were also made to Section 1877 by the enactment of the Social Security Act Amendment of 1994.

The Health Care Financing Administration and the Office of Inspector General have published regulations at various times since 1991. The publications address changes to the statute and seek to disseminate interpretations of Sections 1877 and 1903 of the Social Security Act.

The most recent publication by the Health Care Financing Administration addressing these sections of the Social Security Act occurred earlier this year. On January 4, 2001, the Health Care Financing Administration (HCFA) issued a final rule implementing Stark II. A 90-day comment period has been provided for comments by interested parties. The issuance of this final rule is Phase I and generally becomes effective January 4, 2001.

While Phase I addresses the provisions of paragraphs (a), (b), and (h), of Sections 1877 of the Social Security Act (the Act), Phase II will address paragraphs (c), (d), (e), (f) and (g), as well as the extension of referral prohibition to the Medicaid Program. HCFA states that the second final rule (Phase II) will be published shortly.

Very importantly, Phase I of the final rule includes a provision which generally protects a physician referral to an entity with which the physician has a compensation relationship, as long as the compensation paid to the physician, is at "fair market value". Compensation excluding cash or cash equivalents, with a value of up to $300.00 per year, is also generally excluded.

Additionally, indirect financial relationships are defined in the final rule and an exception has been created for them. HCFA has defined those arrangements, which are at risk for liability, to include a knowledge element. Therefore, the final rule may reduce potential liability to entities that render and submit claims for such services in situations where indirect financial relationships with the referring physician exist, but were unknown.

Another exception is applicable to risk sharing arrangements. The exception under the final rule was created to protect compensation agreements between a managed care organization or an IPA and a physician.

Exceptions are also expanded or modified in several additional instances. For instance, requirements qualifying a practice as a "group practice" have been relaxed. New groups are also now given a twelve-month period to achieve compliance with the 75% rule.

In conclusion, it should be mentioned that one of the first actions taken by the Bush Administration was to place a hold on new regulations until they could be reviewed by the incoming administration. Accordingly, these "final" rules may not truly be final after all.

William Whatley is the Corporate Compliance Officer with Health Group of Alabama.

OIG Advisory Opinions 2000

by Chuck Self
Baptist Health System, Inc.

The OIG - DHHS issued a number of Advisory Opinions for the 2000 calendar year. Unfortunately, the specific fact situations upon which these opinions are based severely limit the ability of hospitals to extrapolate any definitive guidance that will square with their own practices. As has been noted elsewhere, these opinions select "best case scenarios" and consequently offer little assistance to the required arrangements that hospitals find themselves crafting to assist the needs of their own patient constituencies.

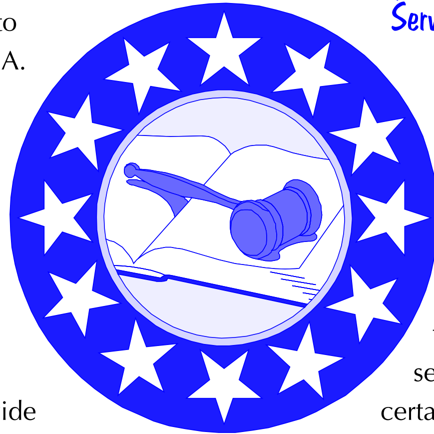
Adv.Op. 00-11: Volunteer Emergency Medical Services

Hospital A wanted to make a charitable donation of $5,000 to an all volunteer (tax exempt) EMS service to be used for the purchase of equipment and paramedic training. Seventy three percent of EMS patients were brought to Hospital A. The OIG concluded that such a donation could constitute prohibited remuneration under the Anti-Kickback Statute if the requisite intent to induce referrals was present, but declined to apply sanctions. Questions pertinent to the inquiry include whether the donation presents a risk of overutilization or increased costs to the Government and whether the donation was a relatively modest, one-time donation and what where the specific uses the monies would go towards.

Adv.Op. 00-9: Voluntary Emergency Medical Services

Hospital A (non-profit/ tax exempt) is the only hospital in the greater City X area. Eleven EMS services transport greater than 85% of their patients to Hospital A. The Regional EMS Council coordinates a region-wide ambulance restocking program with a proposal that the hospital restock the ambulances (with supplies and drugs) of the four "non-billing volunteer services" at no cost and without seeking any reimbursement while "other" ambulance services must pay the fair market value price for any restocked emergency items.

The OIG found this proposal suspect and felt it could constitute prohibited remuneration under the Anti-Kickback Statute if the requisite intent to induce referrals were present. Because of the oversight of the proposal by the Regional EMS Council effecting only the restocking from "emergency" transports, OIG declined to sanction this specific activity.

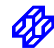


Adv.Op. 00-7: Free Transportation Service

Hospital X (non-profit) offers free transportation services to certain patients who have been referred there for extended courses of treatment (chemotherapy, dialysis, radiation therapy, cardiopulmonary rehab, etc.). Finding that the arrangement could potentially generate prohibited remuneration under the Anti-Kickback Statute, the OIG nonetheless declined to issue sanctions under the specific facts.

Hospital X encompassed a ten-county rural area covering 8,000 square miles (MUAs) and was the only provider of radiation oncology services, only one of two providers of dialysis service and only one of three providers of cardiac rehab services in the area. Public transportation was extremely limited. Costs for this free transportation were not claimed on any Federal health program cost report. Strict criteria for patient eligibility are adhered to and the service was not marketed or advertised.

The OIG declined to assess civil monetary penalties in this instance, but did find that these services provided clearly implicated the fraud provisions of both the Social Security Act and the Anti-Kickback Statute. This author recommends you review the facts set out in this Opinion closely if you represent a rural hospital and analyze the numerous factors that led the OIG to its' decision.



Chuck Self is Vice President — Compliance with Baptist Health System, Inc.

Fraud or Mistake . . . That Is The Question

by Anthony A. Joseph
Johnston Barton Proctor & Powell LLP

Introduction

In the movie The Godfather, Marlon Brando, with his jaws fully inflated and his voice barely above a whisper, coined the phrase "make him an offer he can't refuse." With that command, the Godfather would direct his black clad minions to visit the unsuspecting soul who had piqued the Godfather's attention. There would be no discussion about the merits, and no assessment with respect to the credibility of the source. You either did what you were told or suffered the consequences.

In today's health care fraud investigation environment, the government has taken on the role of Godfather in its use (or misuse) of the False Claims Act ("FCA"). The GAO has reported significant overreaching by some U.S. Attorney's offices. Some hospitals have been threatened with FCA litigation despite the fact that there was clearly insufficient evidence to support the allegations.

With the onerous provisions of the FCA, and the attendant costs and risks associated with such litigation, some health care providers feel they must comply with the request of the Godfather or find themselves "swimming with the fishes." In other words, they are left with the notion that the only rational move is to settle, even if the government's likelihood of success is small. Settlement seems like the only logical and reasonable solution. When a settlement is premised on threats, and not on the merits, it is never clear whether the settling party was truly guilty of fraud or had just made a mistake. Improper settlements under the FCA fail to reveal a clear line of demarcation between mistake and fraud.

The Root Cause

In 1998, HHS-OIG reported that approximately $12.6 billion of health care provider billings were fraudulent. Since the FCA was amended in 1986, the government has recovered over $3.5 billion in FCA cases. Of that $3.5 billion, whistleblowers have received approximately $550 million, with an average recovery of $987,000. With the announcement of the alarming level of fraudulent billing, and the enormous recoveries, health care fraud investigations will continue to be a top priority with the Department of Justice ("DOJ").

Requirements of the False Claims Act

Under the False Claims Act, the damages are trebled, and the subject-defendant is charged with penalties in range of $5,000 to $10,000 (since September 1999, $5,500 to $11,000) per claim. Whistleblowers receive between 15 to 30 percent of the total recovery. When you initiate investigations with those projections, the threat becomes real and serious.

To prove that a person or entity has violated the False Claims Act, the government or plaintiff/relator must prove that the person or entity:

- Knowingly;
- Presented or caused to be presented;
- A false or fraudulent;
- Claim, record or statement.

Congress, and subsequent case law, has made it clear that the FCA does not apply to innocent mistakes, inadvertence, physician errors, negligence, or technical violations. Webster defines "knowingly" as conscious, intentional and deliberate action. The FCA defines "knowingly" as (a) actual knowledge, (b) deliberate ignorance or (c) reckless disregard for the truth. Interestingly, "deliberate ignorance" and "reckless disregard" are not defined in the statute; thus, the "knowingly" requirement is subjected to varying interpretations beyond the universally accepted notion of conscious, intentional or deliberate action.

In many of the cases that have been investigated or litigated, "knowingly" has been stretched beyond the clear intent of the statute. In some cases, overzealous prosecutors and plaintiff/relators have subjected the term to interpretations and theories never before imagined. Notwithstanding, the subject health care provider must still expend the time and resources to investigate and defend the action, always under the onerous threat - real or imagined - of huge damages if the results are negative.

Fear Enhanced

The year 2000 was a record-breaking year for FCA recoveries. The year started off with the DOJ's announcement of a settlement of $385 million with Fresenius, and ended with a record-setting announcement of an $840 million settlement with Columbia/HCA. These settlements, and the number of million dollar settlements in between, continue to generate interest by the government and the plaintiff's bar. While government attorneys and agents do not personally benefit from a recovery, their

office reaps indirect benefits in the form of favorable publicity and increased funding. On the other hand, the whistleblower and his/her attorney reap direct benefits from a recovery - in the range of 15 to 30 percent - whether the recovery is by way of a jury verdict or settlement.

Under HIPAA of 1996, Congress provided $100 million for health care fraud enforcement for FY 1997, with a 15 percent increase each year until 2003, on the condition that the government would collect multiple damages in health care fraud cases. The government projects that it will recover over $9 billion during the next five years.

The above recoveries and expectations will fuel even more aggressive efforts - good or bad, right or wrong - to bring FCA cases. Novel and overzealous prosecutions will become a common event, unless appropriate constraints are placed on these type of investigations.

Outcry Over The Government's Actions

Over two years ago the American Hospital Association ("AHA") voiced a concern over what it perceived to be an abuse of the FCA against health care providers. The AHA also questioned whether the burden of proof in an FCA case - beyond a preponderance - should be the requisite burden. Equally important, there was a universal concern that the government's national initiatives were not well founded and were being used merely as vehicles for recovering sums of monies. It was determined that "demand letters" were sent to hospitals based solely on an assessment of a national computerized billing analysis, without any determination as to whether each of the hospitals receiving a demand letter was guilty or not. The government's analysis was based on the theory that all similarly situated health care providers were engaging in similar conduct. Some of those national initiatives included laboratory billing, the 72-hour window, the prospective payment system (PPS) transfer, and pneumonia up-coding. A study conducted by the GAO determined that out of 93 U.S. Attorney's offices, the majority had participated in at least one of the national initiatives.

To compromise, the Clinton administration, pursuant to a memorandum by Deputy Attorney General Eric Holder, developed DOJ policy guidelines that each U.S. Attorney's office was required to follow in bringing FCA cases. Holder's memo stated, among other things, that each and every office should bring FCA cases in a "fair and even-handed manner."

The GAO was further directed to investigate the effectiveness of the Holder guidelines on the practices employed by the U.S. Attorney's offices in FCA cases. In February 1999, the GAO issued its first report. The report revealed some startling results. The GAO found that a number of investigations were closed without negative actions being taken against the subjects, giving further credence to the industry complaints of meritless threats. The GAO found that many hospitals were threatened with FCA litigation, despite the fact that there was clearly insufficient evidence to support the allegations. Demand letters were sent to a number of hospitals when the government lacked credible evidence that the hospitals had "knowingly" submitted the purported false claims. Some facilities were threatened with FCA suits merely because they were the largest medicare billers in their particular state. Equally startling, the GAO report found "no basis" for the government's allegations in at least 24 cases. The GAO report concluded that the Holder guidelines had little to no effect on the over-reaching behavior of some government attorneys.

Government's Use of Statistical Sampling to Measure Fraud

Before intervening in a False Claims Act case, the government will sometimes advise the subject that there is an investigation in progress, and will seek to determine whether the subject is interested in resolving the case. This is where the Godfather routine kicks into high gear. The government enters these dialogues with the onerous threat of the full force of the FCA statute - trebled damages and $5,000 to $11,000 penalties per claim. At this point, the government has often focused its attention on only one year and on a review of a statistically valid sample of the purported false claims within that one year.

The government will then identify the alleged violation(s), establish a purported "error rate" through information obtained through the fiscal intermediary, and apply the error rate to that universe. The pipe line to continued funding for health care fraud investigations and prosecutions is premised on the government's recovery of double damages. Therefore, the policy has been set that any settlement should result in a minimum recovery of double damages.

The problem with the government's use of the statistical sampling method is that it:

- Shifts the burden of proof from the moving party to the defendant, and
- Reduces the

government's obligation to establish clear fraudulent conduct under the FCA.

The threat of trebled damages and, in some cases, the possibility of exclusion from the Medicare program often produces questionable settlements. Again, given the FCA's onerous provisions and the costs and risks associated with such litigation, the rational move seemingly is to settle, even if the government's likelihood of success is very small.

The Impact of Questionable Settlements

In most civil litigation the vast majority of the cases settle. There are obvious advantages to settling litigation: it saves time and expense, and eliminates the uncertainty of the result. In most cases, despite the merits or the strength of one side over the other, parties can articulate their positions and often meet somewhere in between.

In the FCA context, however, the government starts the investigation with a hammer, pulls out an axe, and points to a bomb. The subject is usually faced with two options: (1) settle for double damages, or (2) bear the risk of treble damages with enormous penalties and possible exclusion from the Medicare program. Faced with these options, settlement often seems to be the only choice.

There are a number of significant impacts of questionable settlements. For starters, such settlements:

- Establish tenuous precedent;
- Perpetuate acceptance of over-reaching tactics;
- Result in theories not being fully analyzed;
- Inappropriately label the subjects as frauds and cheats.

Equally important, sometimes there is no clear discernment as to whether the actions are based on fraud or mistake.

Challenge

Every organized group of professionals exists (a) to educate, (b) for fellowship, (c) to advance their profession, and (d) to make a positive impact on society. Two years ago the hospital industry spoke with one voice and that voice was clearly heard. The health care industry is again under attack. Of course, there are individuals who knowingly and intentionally violate the law. They should be prosecuted. On the other hand, in those instances where mistakes are made, health care providers should not be subjected to the threats of the FCA. In the past, such mistakes were handled administratively, with repayment being the preferred penalty. The health care industry must remain diligent and demand reasonable restraints on the government's use of the False Claims Act. With the new Bush administration comes an opportunity for further careful review and, more important, some constraint.

ALABAMA CHAPTER
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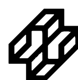
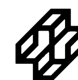
 **2001-2002** 

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LOOKING AHEAD

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