HOOPER LUNDY & BOOKMAN, INC.
HEALTH LAW PERSPECTIVES

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CMS and OIG Release New Charity Care Guidance

On December 16, 2003, the American Hospital Association (AHA) sent a letter to the Secretary of Health and Human Services, Tommy Thompson, seeking guidance and clarification regarding federal program limitations on a hospital's ability to discount from full charges bills for hospital services to low income patients or uninsured and underinsured patients. The AHA letter expressed the collective frustration felt by hospitals who believed that federal Medicare regulations and anti-kickback restrictions prevented them from offering discounted rates to such patients without a significant impact on Medicare payments and Medicare program participation.

In response, OIG issued a guidance document on February 19, 2004 document for hospitals that wish to offer discounts to uninsured patients and patients who cannot afford to pay their hospital bills. The new guidance provides hospitals with a road map that allows significant latitude to discount services to certain segments of their patient population. In addition, Secretary Thompson sent Richard Davidson, the president of the AHA, a reply letter with an extensive set of answers by CMS to frequently asked questions (FAQ). In doing so, Secretary Thompson outlined the position of the full Department of Health and Human Services.

Both the OIG document and CMS FAQ clarify existing policy by stating that no federal law prohibits or restricts a hospital from offering discounts to uninsured patients or underinsured patients who, due to limited financial means, are unable to pay their hospital bills. As stated by Secretary Thompson, "hospitals can provide discounts to uninsured and underinsured patients who cannot afford their hospital bills and to Medicare beneficiaries who cannot afford their Medicare cost-sharing obligations. Nothing in the Medicare program rules or regulations prohibit such discounts."

Additionally, both documents appear to provide hospitals with a great deal of latitude to develop and implement needs-based discount policies for both Medicare and non-Medicare patients without fear of OIG sanctions or an effect on their Medicare payments.

"While some technical issues are still being resolved, the recent guidance on discounts to noninsured patients which has been provided by CMS and the OIG will provide a significant amount of flexibility to hospitals who either wish to provide the discounts, or are being pressured to offer such discounts," said HLB attorney, Brad Tully.

Finally, Secretary Thompson strongly encouraged AHA-member hospitals to take the actions necessary to ensure that uninsured and underinsured Americans of limited means would no longer be required to pay higher rates for their hospital services. Moreover, the OIG made clear that they have never excluded or attempted to exclude a provider or supplier for offering discounts to an uninsured or underinsured patient.

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Following are some of the key issues addressed by the OIG and CMS:

- The anti-kickback laws do not prohibit discounts to uninsured patients, those without private insurance or access to state and federal health programs. However, in the case of underinsured patients, hospitals should exercise care to ensure that such discounts are not tied directly or indirectly to the furnishing of items or services payable by a federal health care program.
- Discounts to underinsured patients could potentially violate the anti-kickback laws if one purpose of the discount was to generate business payable by federal health care programs.
- Under the fraud and abuse laws, Medicare cost sharing amounts may be waived by a hospital so long as the waiver is not advertised, not routine, and only made after there has been a good faith and individualized determination of financial need or a failure to collect the amounts using reasonable collection efforts. Financial need should be based on objective locally based written established financial guidelines that must consistently be applied.
- No OIG rules or regulations require a hospital to engage in any particular collection practices. Moreover, hospitals are not required to take low-income patients to court, seize their homes, or to use collection agencies. However, collection practices must be applied uniformly to all patients or a hospital's reimbursement of Medicare bad debt may be jeopardized.
- A hospital's cost-to-charge ration will not be affected so long as full charges are reported for purposes of cost reporting. Nonetheless, discounts not based on ability to pay will impact customary charges used in Medicare's lower of cost or charges (LCC) principle. At the same time, CMS noted that LCC has little relevance to most current Medicare hospital payment systems.

For more information, please contact John Hellow or Peri Lynn Cohen at (310) 551-8111.

Board of Pharmacy Reverses Position on Licensure of LLCs

In a major change of policy, the California Board of Pharmacy has announced that it will begin to issue pharmacy permits to entities formed as a limited liability company (LLC). The Board previously refused to issue pharmacy permits to LLCs based on an interpretation of the law that HLB attorneys have always disagreed with. This change of policy will enable providers such as hospitals, outpatient surgery centers, and pharmacies to be organized as limited liability companies.

"This change is well overdue and will provide greater flexibility and opportunities for many Medi-Cal providers," said HLB attorney Robert Valencia.

For more information, please contact Mr. Valencia at 310.551.8167 or rvalencia@health-law.com.

Law Governing Surgicenter Ownership Ambiguous

A California Superior Court has invalidated the California Department of Health Services' interpretation of surgicenter ownership requirements, in a case filed against DHS by a California physician (*Capen v. Bonta,* Calif SuperCt, Sacramento, No. 02AS05700).

The dispute involves Health & Safety Code Sections 1204 (b) and 1206 (a), which provide exemptions from clinic licensure for doctor-owned surgicenters. DHS has interpreted these sections to require every surgeon who used the clinic to be an owner. As experts for the plaintiffs, HLB contended that DHS' position was inconsistent with its prior interpretations. The court concluded that DHS' position was an interpretation that violated the Administrative Procedures Act (APA) as the two code sections are ambiguous.

"The plain language of neither [code section] states that for a clinic to be exempt from licensure each physician or health care practitioner who practices at the clinic must be an owner or lessee," the court said. "They merely require that the clinic be 'owned or leased and operated . . .by one or more' physicians or licensed health care practitioners."

For more information, please contact Bob Lundy at 310.551.8180 or rlundy@health-law.com.

HLB Assists In First Tenet Hospital Sale

Hooper, Lundy & Bookman is advising Salus Surgical Group in its planned takeover of Century City Hospital, which would be the first Tenet Hospital in Los Angeles County to be transferred to new ownership since the health care system's recent announcement that a number of its California hospitals are to be sold.

"Tenet has operated Century City Hospital under a lease agreement and Salus is negotiating to enter into a new lease and continue operations of the Hospital"

said HLB attorney David Henninger, who is representing Salus.

Century City Hospital, a 186 bed general acute care hospital, will be temporarily closed for remodeling following termination of Tenet's lease, which is expected to occur at the end of April, Mr. Henninger noted.

For more information, please contact Mr. Henninger at 310.551.8177 or dhenninger@health-law.com.

DHS Issues Medi-Cal Rule Changes via Bulletin

New legislation, which became effective January 1, 2004 (known as SB 857), includes specific rules and timelines for the submission and processing of Medi-Cal program provider applications. SB 857 contains a provision which specifically grants the Department of Health Services (DHS) the authority to implement, interpret, or make specific certain sections of the new law through the issuance of provider bulletins rather than formally promulgated regulations.

The first such informal guidance regarding the new provider enrollment rules was issued by DHS in a February 2004 Provider Bulletin. This bulletin summarizes the provisions of Welfare and Institutions Code Section 14043.26 (c) and explains the procedures and requirements for how a provider can request consideration for enrollment in the Medi-Cal program as a "Preferred Provisional Provider". The procedures are effective for all application packages received by DHS on or after March 17, 2004.

Preferred Provisional Provider status grants a provider provisional enrollment in the Medi-Cal program within 90 days of submission of an application as opposed to the 180 days it takes all other providers. As of now, only physicians can be considered for enrollment as Preferred Provisional Providers. However, DHS is authorized by SB 857 to adopt similar criteria for other providers in the future.

If a provider does not meet the criteria for Preferred Provisional Provider status or the application package fails to meet the requirements set forth, DHS will notify the provider of such within 90 days of receipt of the application and the application will then be processed within 180 days from the date the notice was sent by DHS. Therefore, if a provider attempts to receive Preferred Provisional Provider status when it does not qualify for such status, the provider's application process will be extended an additional 90 days for a total processing time of 9 months rather than the 6 months it would have take to process any other provider's application.

The DHS criteria to qualify for Preferred Provider Status include:

- The words "Preferred Provisional Provider" must be clearly typed in bold print at the top of the first page of the Medi-Cal Physician Application/Agreement (DHS 6210).
- Applicant must hold a current physician or surgeon license issued by the Medical Board of California or the Osteopathic Medical Board of California, which has not been revoked, suspended, placed on probation, or subjected to any other limitations. Include a copy of the license in the application package.
- Applicant must include a letter on the relevant institution's or organization's letterhead stating facts establishing that one of the following is met:
  - Physician is a current faculty member of a teaching hospital or a children's hospital, accredited by JCAHO or AOA; or
  - Physician is credentialed by a health care service plan licensed under Knox-Keene Health Care Service Plan Act of 1975; or
  - Physician is credentialed by a county organized health system; or
  - Physician is a current member in good standing of a group credentialed by a health care service plan licensed under Knox-Keene Health Care Service Plan Act of 1975.
- Application package must include a letter from a general acute care hospital accredited by JCAHO or AOA stating that applicant has full, current, unrevoked, unsuspended privileges.
- Application package must include documentation from the Healthcare Integrity and Protection Data Bank/National Practitioner Data Bank verifying that the database has no adverse entries regarding the applicant.
- Application package must include a *Cover Letter for Preferred Provisional Provider Enrollment* in which the applicant declares under penalty of perjury under the laws of California that he or she meets all required criteria. The February 2004 provider bulletin contains a form sample cover letter to be used.

For further information contact Stacie K. Neroni at (310) 551-8124 or sneroni@health-law.com.

CALENDAR

April 2-4 HLB Attorneys Lloyd Bookman, John Hellow and Jon Neustadter speak at the American Health Lawyers Association Institute on Medicare and Medicaid Payments at the Baltimore Marriot Waterfront. Mr. Neustadter speaks on PRRB practice and jurisdiction, Mr. Bookman moderates a panel on PRRB and CMS Administrator developments, and Mr. Hellow speaks on recent DSH litigation.

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