HLB
Hooper, Lundy & Bookman, PC
HEALTH CARE LAWYERS & ADVISORS

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Distinguished Litigator Jay Hartz Retires

HLB Partner Jay Hartz has announced his retirement after nearly 25 years with the firm.

"Jay has been a pivotal force at the firm. As we grew, his considerable litigation expertise attracted and mentored other talented litigators, allowing our litigation practice to keep pace with the growth of the firm," said Managing Partner Robert Lundy. "Jay is irreplaceable, but we are grateful for the legacy he leaves the firm upon his retirement."

Mr. Hartz was the firm's first Litigation Department Chair. Under his leadership, the firm's ability to serve clients in disputes with payors and other private parties expanded exponentially.

"I was very grateful to spend much of my career in such a great law firm with colleagues that I liked and respected, and who were smart, knowledgeable, always at the cutting edge of health care, and committed to helping their clients," said Mr. Hartz.

Recently, Mr. Hartz reflected on his career at HLB.

> Every lawyer treasures the occasion or occasions when they achieve a result that conventional wisdom said was not possible, and all the more so when your client is in the right. For me, the most memorable such occasion involved my representation of a physician before the California Medical Board.
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> The Board had filed a lengthy Accusation against the physician seeking to revoke his license. The Accusation appeared to be politically motivated. The physician consulted six other attorneys who all told him that he didn't have a chance, and he should just surrender his license and save his money. He refused to accept that outcome without a fight.
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> So we conducted what I was told was the longest hearing in the history of the Medical Board, which resulted in half the charges being thrown out, and then filed a petition with the Superior Court, which resulted in each of the remaining charges being thrown out. The physician practiced for another 10-15 years before retiring, and had no further problems with the Medical Board.

In addition to particular high moments, such as that described above, Mr. Hartz also reflected on his experience with firm clients.

"The most rewarding aspect of my practice was the opportunity to work with and get to know some of our many smart, focused, talented clients, to have the opportunity to learn more about their businesses, and to

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help them solve problems," he said. "I can't think of a better platform than our law practice for the opportunity to meet incredible people doing incredible things."

"Jay has been a friend and colleague for nearly 40 years, said HLB Founding Partner Patric Hooper. "He's one of a kind-- unflappable and extremely articulate."

"I have practiced with Jay since I began my career," added HLB Founding Partner, Lloyd Bookman. "Jay showed that you can be an outstanding and effective litigator while being a decent human being, and remaining true to yourself. He will be sorely missed."

IRS Issues Final Regulations on Financial Assistance Policies and Community Health Needs Assessments

By Nina Adatia Marsden

On December 31, 2014, the Internal Revenue Service (IRS) issued its final regulations governing financial assistance policies and community health needs assessments for charitable hospitals. The regulations are codified in Internal Revenue Code Section 501(r), and apply to all hospitals that are tax-exempt under Internal Revenue Code Section 501(c)(3). This article provides an overview of some of the requirements discussed in the new regulations, as well as an analysis of how those requirements compare to the state-specific requirements for charity and discounted care established by California's Hospital Fair Pricing Policies (HFPP) law and the state-specific requirements for community health needs reports under California's Community Benefit law.

Many of the requirements discussed in IRS's final rules were first introduced by the Affordable Care Act in 2010. In 2012, the IRS had issued proposed rules to provide additional guidance on the statutory requirements, but it was not until late last year that the agency issued its final rules. Importantly, the final rules explicitly state that they are applicable to taxable years beginning after December 29, 2015, and that hospitals may rely on a "reasonable, good faith" interpretation for earlier years. The IRS will consider a hospital to have met this standard if it has complied with either the proposed or final rules for those earlier years. In the event a hospital is determined to be out of compliance with the requirements, the hospital risks being taxed on income for those years of noncompliance or loss of its tax-exempt status altogether.

The final regulations provide guidance on four primary areas: (1) financial assistance policies; (2) charge limitations; (3) billing and collections; and (4) community health needs assessments (CHNA).

The IRS final rules provide that hospitals must establish and widely publicize a financial assistance policy (FAP) that clearly describes the eligibility criteria for obtaining financial assistance and the method for applying for such assistance. At a minimum, the financial assistance policy must apply to emergency and other medically necessary care, and a hospital must provide a list of the providers that deliver emergency or other medical care that are covered by the financial assistance policy. California's HFPP, by contrast, likely applies to all hospital services, and does not require a hospital to produce a list that designates which providers are covered by the policy.

The IRS final rules further provide that the hospital must, either in its FAP or in a separate billing and collections policy, describe action that may be taken relating to obtaining payment, such as extraordinary collection actions (ECAs). They must also outline the process and timing for taking that action, describe what reasonable efforts the hospital will make to determine whether an individual is eligible for financial assistance before using ECAs, and identify a body within the hospital that will have the authority to determine whether the hospital has made reasonable efforts to determine eligibility. California's HFPP does not require a hospital's charity care/discount care policy to have the same information, so hospitals should review their policies to ensure that the information required by the IRS is present.

The IRS final rules further require a hospital to identify the information it uses to determine eligibility (other than information gathered directly from the patient) and the circumstances under which it uses other eligibility determinations to determine "presumptive eligibility" for FAP purposes. By contrast, the California's HFPP law allows hospitals to use recent pay stubs or income tax returns for eligibility purposes and does not recognize the concept of "presumptive eligibility." The IRS final rules also provide that a hospital organization has the option to establish a FAP that is identical to the FAP for other facilities or establish a joint policy that is shared by multiple hospital facilities. California's HFPP law, however, requires every hospital to have its own charity

HLB Briefs

Alex Brill, HLB's Economic Policy Advisor, has produced *An Examination of CMS's Dialysis Star Rating System.* With CMS employing more "star rating" and other value-based payment reforms, the paper has implications beyond dialysis providers. The full report is available at: http://www.health-law.com/media/news/282_CMS Dialysis Star Rating System Analysis 031715.pdf.

care/discounted care policy.

The IRS final rules also establish charge limits for services provided by hospitals under their FAPs. Specifically, hospitals may not charge individuals eligible for financial assistance more for emergency or other medically necessary care than the amounts generally billed (AGB) to patients with insurance, including Medicare, Medicaid, or private commercial insurance. The final rules establish two methods for determining the AGB. Under the first method, the look-back method, a hospital may develop a single percentage or multiple percentages for different categories of service of gross charges based on (a) Medicare fee-for-service paid claims during the last 12 months; (b) Medicare fee-for-service and private health insurer paid claims during the last 12 months; or (c) Medicaid paid claims during the last 12 months, either alone or in conjunction with Medicare or Medicare and private insurance. Under the second method, the prospective Medicare or Medicaid method, the hospital estimates estimated payment amounts if the patient was a Medicare fee-for-service or Medicaid beneficiary. The final rules specifically provide that a hospital may only use one method at a time, but it may change its chosen method at any time. By contrast, the California HFPP law requires a hospital to limit charges to eligible individuals to the higher of expected payment from Medicare, Medi-Cal, or another government-sponsored health program in which the hospital participates.

The final rules explicitly prohibit a hospital's use of ECAs until a hospital makes reasonable efforts to determine whether an individual is eligible for financial assistance. ECAs are specifically defined to include activities such as reporting adverse information to credit agencies, garnishing wages, commencing a civil action against an individual, deferring or denying medically necessary care because of nonpayment on a bill for previously provided care that was covered under the FAP, or requiring payment before providing medically necessary care because of outstanding bills for prior care, among others.

The final rules provide that a hospital has made reasonable efforts if it has made a determination that an individual is FAP-eligible based on information provided by a third party, or on a prior FAP-eligibility determination, and (1) notifies the patient of the basis for the presumptive determination and how to apply for more generous assistance, (2) gives the individual reasonable time to apply for more generous assistance before initiating ECAs, and (3) determines whether the patient is entitled to more generous assistance if the application is timely submitted.

The rules further provide that a hospital has made reasonable efforts if it (1) notifies the individual about the FAP before commencing any ECAs and refrains from commencing ECAs for at least 120 days from the date the hospital provides the first post-discharge billing statement for the care provided; (2) in the case of an individual who provides

Hooper, Lundy & Bookman & HFMA Southern California Chapter Present 2015 Provider Managed Care Update:

Post ACA Changes to Government and Private Managed Care Markets

The Affordable Care Act continues to impact the managed care marketplace in both anticipated and unanticipated ways. Health care providers and suppliers face an ongoing panoply of complex choices, many of which have a significant impact not only on patient care and relationships with other providers, but also on their own financial and operational health.

At the heart of many post-ACA changes is managed care. In this one-day seminar exclusively for health care providers, Hooper, Lundy & Bookman (HLB) provides a comprehensive look at the current and future states of both the Government and Private Managed Care Marketplaces.

HLB Attorneys and firm Government Relations and Public Policy Managing Director, will be joined by several guest presenters to address the most pressing questions providers are asking today.

HLB presenters include Daron Tooch, Felicia Sze, Mark Reagan, Charles Oppenheim, Mark Johnson, Keith Fontenot, Katrina Pagonis, Amanda Hayes-Kibreab, Michael Houske, Peter Brachman and David Vernon. We will be joined by Guest Presenters Margaret Tatar, Steve Lieberman, Kevin Forster and Darin Libby.

Following the seminar, HLB's Diversity Initiative will host a wine and cheese event for attendees.

For additional information or to register, see our announcement here: http://www.health-law.com/news-room-events-54.html

an incomplete application packet, the hospital notifies the individual about how to complete the FAP application and gives the individual a reasonable opportunity to do so; and (3) in the case of an individual who provides a complete application during the application period, the hospital determines whether the individual is FAP-eligible.

The final rules further provide that a hospital must properly notify individuals about its FAP. A hospital has provided proper notice where it (1) provides the individual with written notice regarding availability of financial assistance, identifies the ECAs that the hospital intends to initiate, and states a deadline after which the ECAs may commence (no earlier than 30 days following the notice); (2) provides the individual with a plain language summary of the FAP; and (3) makes a reasonable effort to orally notify the individual about the hospital facility's FAP and how the individual may obtain assistance with the FAP application process.

The California HFPP law outlines specific requirements for collection activities as well, but those state-imposed requirements differ from the IRS' requirements in a number of ways. For example, the HFPP law establishes longer timelines during which a hospital may not commence civil action or even report adverse information to a credit reporting agency, and it prohibits wage garnishments or liens on primary residences. The HFPP law also provides specific language that must be included in notices that a hospital is required to provide to patients before commencing collection activities. Accordingly, hospitals that are subject to the federal and state requirements should carefully review their financial assistance policies and procedures to ensure compliance with both.

IRS regulations require tax-exempt hospitals to perform a CHNA at least once every three years. In its CHNA, a hospital must define the community it serves, assess the health needs of its community, solicit and consider input from the community, document the CHNA in a written report, and make the CHNA report widely available to the public. Under the final rules, hospitals are also required to adopt an implementation strategy to meet the needs identified in its CHNA and publish this strategy as part of its annual tax filing. Further, the final rules expand the scope of "health needs" as it was defined in the proposed regulations to include the need to prevent illness, ensure adequate nutrition, and to address social, behavioral, and environmental factors that influence health in the community.

The final rules also require that all CHNAs following the initial CHNA include an evaluation of the impact of the actions the hospital has taken to address what it had identified as the health needs of the community. The California Community Benefit law requires certain tax-exempt hospitals to prepare a community benefit plan report. While many of the requirements for this report overlap with the requirements for the federally-required CHNA, there are significant differences, including how often a plan must be updated or prepared, and whether hospitals under common control can prepare a single report. Further, the federal regulations contain many more particular requirements regarding the plans, and establish specific penalties for failure to comply with the requirements, while the state law does not.

On March 10, 2015, the IRS issued Revenue Procedure 2015-21, which provides additional guidance on what will be a considered a failure to satisfy the requirements of the final regulations, as well as information on the consequences of such failure. Tax-exempt hospitals should carefully review their existing FAPs and CHNAs to ensure compliance with these IRS final regulations beginning in tax years beginning after December 29, 2015, and California tax-exempt hospitals should pay particular attention to how any changes to their FAPs and CHNAs and related procedures will affect their compliance with state-level requirements.

For additional information, please contact Nina Adatia Marsden, John Hellow or Lloyd Bookman in Los Angeles at 310.551.8111.

CMS Innovation Center Releases Oncology Demo

On February 12, 2015, the Center for Medicare and Medicaid Innovation (Innovation Center) announced a new multi-payer payment and care delivery model to support better care coordination for cancer care. The model is primarily focused on physician practices in Medicare that provide chemotherapy, though other treatment modalities can be included. Beneficiaries who are in Medicare fee-for-service and being treated with chemotherapy in a participating practice for any major cancer (roughly 90%) will be included.

The practice will be responsible for ***total cost of care*** of the patients in the model, i.e., Part A and B services as well as oncology-related Part D expenditures. The new Oncology Care Model will include 24-hour access to practitioners for beneficiaries undergoing treatment with an emphasis on coordinated, person-centered care, aimed at rewarding value of care, rather than volume.

Physician group practices and solo practitioners that provide chemotherapy for cancer and are currently enrolled in Medicare may apply to participate. In addition, "other payers," including commercial insurers, Medicare Advantage plans, state programs, and Medicaid managed care plans, are also encouraged to apply. CMS notes in the request for applications (RFA) that it will look more favorably on applications from practices that show collaboration with other payers. In addition, CMS will look to markets where one or more payers have expressed interest, by having filed a Letter of Intent by April 9, 2015, and then promote collaboration between practices and payers in those markets. Payers will be expected to employ the same two-part payment model

as CMS, but will have more flexibility on other model parameters, such as benchmarking.

This initiative has been under development for more than two years. CMS had considered a bundled payment system, but deferred on that approach after hearing from stakeholders about the financial risks associated with high cost chemotherapy drugs. While the cost of chemotherapy drugs—both Part B administered and Part D—are a major driver in cancer care costs, the model makes no changes in the current ASP+6, nor Part D. And, participating practices continue to be paid for services under the current FFS payment rules.

However, in order to help reduce total cost of care, such as unnecessary hospitalizations and emergency department visits, participating practices will receive a monthly care management payment of $160 for each Medicare fee-for-service beneficiary cared for during a six month episode of care to support comprehensive, coordinated patient care. To promote broader oncology practice transformation—delivery of quality care and lower costs—practices will be eligible for performance-based payments. Unlike other Innovation Center initiatives, participating in an ACO or other shared savings programs, is not a bar to participation in the OCM—with the exception of the Transforming Clinical Practices Initiative (TCPI).

As with other CMS "shared savings" models, CMS will establish benchmark targets, based on prior claims history of "assigned" beneficiaries, and adjust for geographic and other factors, before applying a 4% discount. In addition, CMS will apply a risk adjustment factor, which may be modified over the course of the 5 year model, as additional data is available. For the first two years of the model, practices will be under a one-sided model, in which they will be eligible for bonus payments, but not liable for losses. Beginning in year 3, practices will be eligible for a two-sided risk, under a lower 2.75% discount target, but also liable for losses. Practices will report, on a set of quality and process measures, which will also affect the amount of any performance bonus. In addition, practices will be expected to utilize an ONC certified electronic health record (EHR) and document care plans in accordance with the Institute of Medicine's Care Management Plan and the National Cancer Institute's Patient Navigation criteria.

Non-binding Letters of Intent for practices are due May 7, 2015. In each case, LoI's will be posted on the CMS Innovation web-site so that payers and practices can identify potential partners in their respective markets. Applications for both are due June 18, 2015. CMS expects to launch the model with 100 practices in the spring of 2016. CMS expects to make some modifications to the RFA as they receive further stakeholder questions and input. Updates, along with copies of information on the OCM can be found at the following web link: http://innovation.cms.gov/initiatives/Oncology-Care/

HLB's Government Relations and Public Policy Advisors have been active on behalf of clients over the past two plus years bringing policy, "real world" practice issues, and data to the attention of CMS as it developed this important initiative. For more information, please contact Marty Corry or Kelly Lavin Delmore in Washington, D.C. at 202.580.7700.

CALENDAR

March 5	**LTC Risk Legal Forum Summit 2015, Las Vegas** James Segroves presented *Alternative Dispute Resolution Best Practices.*
March 13	**Health Care Roundtable – Chief Compliance Officers, Scottsdale, AZ** Steve Lipton presented *EMTALA Update.*
March 24	**Joint LACBA-LACMA, LACBA Conference** Glenn Solomon presented *Reimbursement Disputes following the CHCC Case*.
March 25	**AHL Webinar: ACO Credentialing and Peer Review: Essetial Tools for Effective Clinical Integra**tion Jennifer Hansen Co-presented
March 26-27	**AHLA Institute on Medicare and Medicaid Payment Issues, Baltimore** Robert Roth is Program Chair and co-presented ***Hot Topics in Overpayments and Stark Self-Disclosure;*** John Hellow co-presented *Hospital Inpatient IPPS Update;* Lloyd Bookman presented *Medicaid Litigation Update*.
March 31	**Medtrade Spring Convention, Las Vegas** Felicia Sze presents *Managed Care Contracting: Cutting Through the Legalese and Managing the Managed Care Relationship: Enforcing Your Contracts with Plans.*
April 15	**HFMA San Diego Seminar on Improving the Payer & Provider Relationship,** Jennifer Hansen and Peter Brachman co-present *Working Collaboratively with Payors to Resolve Disputes.*

CALENDAR cont'd

April 19	**CSHA Annual Meeting & Spring Seminar, Huntington Beach** **Charles Oppenheim and Ben Durie present *Recent Developments and Practical Tips or Stark Self Disclosure.***
April 23	**Health Journalism 2015, Santa Clara, CA** Stephen Phillips is a panel participant for *HIPAA: The ins, the outs, and how to navigate.*
April 28, 30	**Hooper, Lundy & Bookman Managed Care Seminar for Health Care Providers, Oakland and Los Angeles.** For more information, see our announcement at http://www.health-law.com/newsroom-events-54.html.
May 7	**Webinar: Hooper, Lundy & Bookman Presents: Privacy Breaches: How to Prepare and Respond.** Stephen Phillips and Paul Smith present. For additional information and registration, see our announcement at http://www.health-law.com/newsroom-events-56.html.
May 8	**SCARHM 35th Annual Educational Conference, Rancho Mirage** Steve Lipton and Nina Adatia Marsden present *Legislative/Regulatory Update.*
May 20, 21	**44th Annual CAMMS Educational Forum, Universal City, CA** Jennifer Hansen and Katherine Dru present *Privileging for New or Novel Procedures or Treatments;* Ross Campbell and Ruby Wood present *Complying with Reporting Requirements, Responding to Subpoenas and Sharing Peer Review Information.*

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