KING & SPALDING

Health Headlines

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District Court Upholds CMS's Disallowance Of Illinois Medicaid "Provider Tax" – Twenty-six cost-reimbursed hospitals (*e.g.,* critical access hospitals) in Illinois challenged the Centers for Medicare and Medicaid Services' (CMS) denial of approximately $4 million in costs claimed by the hospitals for a tax assessment levied upon each hospital by the State of Illinois as a part of the state's financing of its Medicaid program. The hospitals claimed that the tax assessment was an allowable cost under the applicable Medicare regulations and Provider Reimbursement Manual (PRM) Sections 2122.1 & 2122.2. According to the hospitals, the tax assessment was approved by CMS as part of the Illinois State Plan for its Medicaid program, and should therefore be considered an allowable cost because it was not specifically excluded by Section 2122.2 of the PRM that lists "Taxes Not Allowable as Costs." In contrast, the CMS Administrator contended that the tax assessment must be offset by the "refund" the hospitals received from the payment fund established by the Illinois Medicaid program, and that the hospitals did not truly "incur" the costs based on the nature of the tax assessment.

The U.S. District Court for the Central District of Illinois dismissed the hospitals' claims and ruled in favor of CMS's interpretation that the hospitals could not claim the tax assessment as an allowable cost. *Abraham Lincoln Mem. Hosp. v. Sebelius*, No. 3:10-cv-03122 (Jun. 8, 2011, C. D. Ill.). The Court found that the full tax assessment was not an incurred cost because under the terms of the Illinois statute, the hospitals did not have to pay the tax until the hospitals received the fund payments from the Medicaid program. The Court held that CMS's approval of the Medicaid State Plan Amendments incorporating the tax assessment did not constitute a determination by CMS that the tax assessments were not refunded by the Medicaid fund payments to the hospitals. According to the Court, "finding that the tax was a permissible tax for purposes of matching federal funds under Medicaid is not dispositive of whether those same taxes are actually incurred and are 'reasonable costs' under the Medicare statute."

The Court's decision adds support for the "clarification" published by CMS in an August 16, 2010 rulemaking statement (adopted after the litigation was ongoing) that Sections 2122.1 and 2122.2 of the PRM regarding allowable taxes must be read in the context of the general rules governing Medicare cost reimbursement, which provide in part that the "true costs of the goods or services is the *net amount* actually paid for them." With a variety of state tax financing mechanisms for the Medicaid program across the several states, the determination of an allowable tax may become a complicated analysis. While there are a limited number of hospitals for which reasonable cost reimbursement is still relevant, for those hospitals, the Illinois' Court decision and recent CMS policy instruct that a careful evaluation of the particulars of a Medicaid provider tax scheme will be necessary for determining whether such taxes can be claimed as an allowable cost under the Medicare program.

For a copy of the decision, click **here**.

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An IRS Advisory Committee Recommends Changes To IRS Rules For Group Exemptions – The Advisory

Committee on Tax Exempt and Government Entities (ACT) presented to the Internal Revenue Service (IRS) on June 15 its tenth annual report, including recommendations for significant changes to IRS group tax-exemption procedures. If adopted, these changes would be applicable to tax-exempt healthcare organizations that obtain their tax-exempt status as a result of a group exemption and that file with other group members an aggregate Form 990 annual return.

For more than 70 years, the IRS has permitted certain affiliated organizations to obtain recognition of tax-exempt status on a group basis, rather than by filing separate applications for tax-exemption. Group exemption holders also have the option of filing an aggregated IRS Form 990 annual return for two or more subordinate organizations, thus relieving those subordinate organizations from having to file separate Forms 990. Forms 990 filed on a group basis have the effect of aggregating information for multiple organizations in one return, and they generally do not permit the reader to access certain information relating to individual organizations included in the aggregate return.

In its report, the ACT recommended, among other things, elimination of group exemption holders' ability to file Form 990 returns on an aggregate basis for subordinate organizations, on the grounds that allowing group exemption holders to file one Form 990 return for the subordinate organizations does not provide adequate transparency about the activities of subordinate organizations covered by group exemptions. Forms 990, which must be made available to the public, require the filing organization to disclose, among other things, its governance practices, executive compensation, activities and finances. If the IRS and the Department of Treasury adopt this recommendation, each organization covered by a group exemption would be required to file its own annual Form 990.

The ACT also recommended that there be a "significant transition period" for existing groups to come into compliance with any changes to the group ruling procedures. It also recommended that special consideration be given to existing church group exemptions (some of which include hospitals and other healthcare providers as subordinate organizations), as some church group exemptions have tens of thousands of subordinate organizations and have been in existence for 60 years or more.

Although the ACT's report recommended changes to Form 990 reporting for organizations that obtain tax-exempt status under a group exemption letter, it also stated the ACT's belief that the group exemption process continues to provide an appropriate mechanism for central organizations to seek recognition of exemption on a group basis for organizations under a central organizations general supervision or control. Accordingly, the ACT did not recommend changes to current group exemption application procedures.

For a copy of the ACT's full report, click **here**. The part of the report addressing group exemption procedures begins on page 291 of the full report.

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Eighth Circuit Denies Antitrust Claims Against Catheter Supplier For Contracting Practices With Group Purchasing Organizations – On June 8, 2011, the Eighth Circuit Court of Appeals (the Eighth Circuit) affirmed the U. S. District Court for the Eastern District of Missouri's decision that the contracting practices of C.R. Bard, Inc. (Bard), a leading supplier of Foley catheters, did not violate antitrust laws. *See Southeast Missouri Hosp. v. C.R. Bard, Inc.*, 2011 WL 2201067 (8th Cir. 2011). Saint Francis Medical Center (Cape Girardeau, Missouri) (Saint Francis), brought antitrust claims against Bard, alleging that Bard "abuses its dominant position in the catheter market in contracting with [group purchasing organizations], inflating prices for hospitals," and more specifically, that the sole-source provisions, share-based discounts, and bundled discounts in Bard's contracts with group purchasing organizations (GPOs) are impermissible.

GPOs are organizations formed by a group of hospitals in order to negotiate more favorable contracts with suppliers on behalf of member hospitals. Hospital participation in GPOs is voluntary, and member hospitals are permitted to negotiate their own prices and purchase supplies "off-contract" if they wish.

At the heart of Saint Francis's arguments was the notion that Bard's GPO contracts are "*de facto* exclusionary because the discount prices are so attractive that hospitals cannot afford to forgo them." Relying upon Eighth Circuit precedent and its

determination that Saint Francis had failed to identify a relevant submarket (a necessary element of claims under sections 1 and 2 of the Sherman Act and section 3 of the Clayton Act), the Eighth Circuit upheld the lower court's decision that bundled discounts did not unreasonably restrain trade and reminded the parties that "cutting prices in order to increase business often is the very essence of competition."

A copy of the decision is available **here**.

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Federal Court Holds In Remand To State Court That HIPAA Violation Can Provide A Standard On Which To Base A State Law Negligence Per Se Claim – On June 14, 2011, the U.S. District Court for the Eastern District of Missouri declined to exercise supplemental jurisdiction over a Plaintiff's state law negligence per se claim premised on Washington University's (Defendant) alleged violation of the Health Insurance Portability and Accountability Act (HIPAA). I.S., *Plaintiff v. Washington Univ.*, No. 4:11-cvv-00235-SNLJ (E.D. Missouri, Opinion Filed June 14, 2011).

According to her complaint, Plaintiff received treatment from Washington University for colon cancer. While being treated by Defendant, Plaintiff authorized Washington University to submit only medical information to her employer in support of her medical leave. Plaintiff alleges, however, that Washington University submitted additional protected health information to her employer without authorization, including information regarding Plaintiff's HIV status, mental health issues and insomnia treatments. Plaintiff filed suit against Washington University in state court alleging, among other things, negligence per se. To establish negligence per se, Plaintiff cited to Washington University's alleged HIPAA violation as a standard. Washington University removed the case to federal court and Plaintiff filed a motion for remand. Washington University contended that Plaintiff's negligence per se claim was "simply a thinly-disguised attempt to bring a private cause of action for violation of [HIPAA]." Although Plaintiff conceded that HIPAA did not provide for a private right of action, Plaintiff stated that it only referenced "HIPAA in order to establish the standard of care by which to adjudge whether defendant's acts were negligent." Agreeing with Plaintiff, the court found that the Plaintiff stated a claim for negligence per se based on Washington University's alleged violation of HIPAA. The court also found that Plaintiff's reference to HIPAA in her negligence per se claim did not raise any compelling federal interest nor present a substantial federal question. Accordingly, the court remanded Plaintiff's negligence per se claim back to state court.

The case is accessible by clicking **here**.

Reporter, *Adam Robison*, Houston, +1 713 276 7306, arobison@kslaw.com.

Bipartisan Group Requests CMS And OIG Address Concerns Regarding Physician-Owned Distributors – A bipartisan group of senators, including Finance Committee Chairman Max Baucus (D-Mont.) and Finance Committee Ranking Member Orrin G. Hatch (R-Utah), have requested that the Centers for Medicare and Medicaid Services (CMS) and the U.S. Health and Human Services Office of Inspector General (OIG) provide additional guidance regarding the legality of physician-owned distributors (PODs), citing patient safety concerns and possible federal healthcare program fraud and abuse due to the heightened potential for physician conflicts of interest. Generally, the concern is that a physician's financial interest in a POD that sells products ordered or used by the physician to a hospital where the physician performs procedures will influence inappropriately the physician's selection of products, the physician's decision whether to perform procedures using the products, or the physician's decision of facilities at which to perform procedures using the products because the physician would profit from the hospital's purchase of the products from the POD.

Specifically, the senators, via a letter dated June 9, 2011, requested that the OIG: (1) conduct an inquiry into current structures and activities of PODs; and (2) report the results of the inquiry along with recommendations for further action that should be taken by the OIG and Congress to address patient safety and fraud and abuse risks. In their letter to the OIG, the senators state that the OIG's prior guidance regarding the legality of PODs is insufficient and unclear. The letter also states the Senators' concern "that guidance alone, in the absence of any visible enforcement proceedings, may be insufficient to stop the growth of those entities that do not appear to be structured with the appropriate safeguards." The letter notes the substantial growth of PODs in the spine and total joint area, in particular, over the past 18 to 24 months.

In a separate June 9, 2011 letter to CMS, the senators requested that CMS: (1) examine the physician ownership and investment interests presented by PODs and ensure those are addressed in the final reporting requirements under the "Sunshine Act," including disclosure requirements applicable to group purchasing organizations (GPOs); and (2) address POD models when developing final regulations regarding accountable care organizations (ACOs). The letter expressly states that "[t]he final rule should prohibit ACOs from purchasing products or services from entities that are owned by physicians participating in the ACO." The letter also states that the final regulation should "[make] clear that waivers of Stark and Anti-Kickback laws [for ACOs] should not extend to PODs."

Senators Herb Kohl (D-Wis.), Chairman of the Special Committee on Aging; Bob Corker (R-Tenn.), Ranking Member of the Special Committee on Aging; and Charles Grassley (R-Iowa), Ranking Member of the Judiciary Committee, joined Senators Hatch and Baucus in the letters to CMS and OIG. In addition to the letters, Senator Hatch released a detailed paper drafted by the Senate Finance Committee Minority Staff regarding the proliferation of, and concerns presented by, PODs.

For a copy of the Senate Finance Committee Minority Staff paper on PODs, click **here**. For a copy of the June 9 letter to OIG, click **here**. For a copy of the June 9 letter to CMS, click **here**.

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