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Collaboration, evacuation failures compounded problems for Gulf Coast nursing homes

by Anuradha Gupta, J.D., Contributing Editor

A lack of collaboration between state and local emergency entities in the Gulf Coast prevented nursing homes from efficiently and adequately responding to the hurricane disaster, according to a report issued by the Office of Inspector General (OIG). Nursing homes that were evacuated due to the emergency also experienced more problems than those that decided not to move residents, the report revealed. The OIG recommended that CMS strengthen federal certification standards for nursing home emergency plans. Communication between state and local emergency entities and nursing homes should also be encouraged.

Universal problems. The OIG's report revealed that the effect of the hurricanes created new problems that could not be anticipated, resulting in impromptu decisions and actions. Despite prior planning, many problems occurred because of inadequate responses and insufficiencies. Nearly all facility administrators believed that their facility's emergency plan would sufficiently accommodate their residents in any hurricane emergency, yet in practice half the plans did not have provisions for ensuring adequate food and water for residents. Additionally, one-quarter of facilities had to deviate from their emergency plan because it lacked proper instructions or there was insufficient means necessary to complete the plan.

Evacuating facilities. All of the nursing home facilities surveyed that chose to evacuate encountered multiple obstacles during and after their evacuations. The following significant issues were reported most commonly by the facilities:

- transportation contracts were not honored;
- evacuation travel took longer than expected;
- patients' complicated medication needs were difficult to meet;
- host facilities were unavailable or inadequately prepared;
- facilities could not maintain adequate staff;
- food and water shortages occurred; and
- timely return of residents to facilities was difficult.

Sheltering in place. For many facilities, circumstances created greater risks in evacuating than sheltering residents in place. Some facility administrators sought to avoid evacuation based on previous negative experiences. Inability to locate adequate alternative facilities for the residents also impacted the decision to shelter in place. Many of these facilities reported that the following factors influenced the decision not to evacuate:

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- the facility structure was sound enough to withstand high winds;
- location limited the degree of high flooding, onsite staff was proficient in emergency response and willing to shelter in place with the patients;
- the surrounding community was willing to supplement facility resources; and
- the poor condition of residents made travel dangerous.

Although sheltering facilities encountered fewer problems than evacuating facilities, two of the facilities faced staffing and resource issues that forced them to evacuate after the storm.

Lack of collaboration. A common element to emergency response failures amongst all facilities, evacuating or sheltering, was the lack of collaboration between state and local emergency entities. Because nursing homes are often categorized as businesses rather than as health care institutions, nursing homes are often not included in community emergency planning. Both facilities and authorities reported that the limited collaboration in preparing for and managing nursing home emergency preparedness and response to hurricanes sometimes impeded nursing home access to resources and information. Although state and local review of emergency plans provided an extra layer of oversight, the actual management of evacuation or sheltering was primarily conducted without the assistance of state and local authorities. Assistance came from parent corporations, "sister" facilities, or resident and staff family members.

Administration of transportation during the hurricane disasters was affected the most by the lack of state and local collaboration, according to nursing home administrators. The primary concern was that transportation contractors were not regulated and despite making promises, failed to make resources available to many facilities. Additionally, city and county transportation sources were needed for use by nursing home residents. The OIG report revealed that local leaders expressed a desire to establish a more comprehensive community transportation plan, including building transportation networks intrastate and interstate. ■

OIG Report, OIG-06-06-00020, August 18, 2006, Health Care Compliance Reporter, ¶530,456.

Trends

Nursing home complaint process flawed

by Stacey Fahrner, J.D., M.P.H, Contributing Editor

Although CMS has instituted policy modifications in recent years, according to a recent report by the Office of Evaluations and Inspections (OEI), weaknesses remain in the nursing home complaint process due in part to a lack of oversight by CMS. The complaint process is the front-line repose system for addressing problems raised by residents, their families, and staff.

Policy changes. Following a recommendation from the government accounting office to increase oversight of complaint investigations, CMS instituted the state performance standards in 2000, which outline state agency complaint investigation procedures, and the ASPEN complaint tracking system in 2004, which serves as a repository for complaint investigation information and allows CMS to evaluate investigations nationwide. According to the report, however, the additional guidance by CMS has not strengthened the complaint process.

State level weaknesses. The report highlights several problematic areas at the state level. First, state agencies failed to investigate some of the most serious nursing home complaints within the required time-frame. Specifically, seven percent of complaints alleging immediate jeopardy were not investigated within the two-day time frame with some states taking up to seven days. Likewise, 27 percent of complaints alleging actual harm were not investigated within the required ten-day period. Failure to conduct a timely investigation is troublesome considering the potential for ongoing harm to residents.

In addition, state agencies did not take full advantage of the ASPEN complaint tracking system (ACTS). Many agencies attributed this failure to a lack of training and technical difficulties with the system itself. According to the report, only five states required the collection of all the items suggested for intake by the *State Operations Manual* (SOM). Finally, follow-up correspondence with complaintants lacked

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Portfolio Managing Editor
Pamela K. Carron, J.D., LL.M

Coordinating Editors
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Stacey Fahrner, J.D., M.P.H.

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Tax–Jeff Carlson, Steve Cooper

Designer
Craig Arritola

Requests for information about article submission and comments from readers are welcome and should be directed to Susan Smith at susan.smith@wolterskluwer.com, Tel. 847-267-2780, Fax 847-267-2514. Customer service inquiries should be directed to 800-449-9525.

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meaningful information such as references to the agency's decision making process. The report stressed that such information is critical because the follow-up letter may be the only correspondence a complaintant has with the state agency.

CMS oversight. The OEI's report identified limitations in CMS oversight of the investigation process in four areas. First, CMS allowed states 20 days to complete investigations of complaints alleging actual harm, which is more lenient than the 10 days allowed under the SOM. Second, CMS conducted few federal oversight and support surveys, which would provide CMS with an opportunity to review the state process. Third, CMS did not follow up on state performance standard failures until a year after the failure occurred. Finally, CMS lacked expertise with the ACT system to use it for oversight or to help state agencies use it.

Recommendations. OEI recommended that CMS strengthen oversight of the nursing home complaint process by requiring states to meet the 10 day SOM deadline for investigations; conduct additional follow-up of state performance standard reviews; and offer additional ACTS training. CMS concurred with most of the recommendations. ■

OIG Report, OEI-01-04-00340, July 1, 2006, Health Care Compliance Reporter, ¶530,451.

IOM: Medication errors common, costly

by Katherine G. Geraghty, J.D., Contributing Editor.

A patient hospitalized in the U.S. will experience at least one medication error each day. This translates into approximately 1.5 million preventable adverse drug events (ADEs) caused by medication errors, costing the U.S. government an estimated $3.5 billion each year. Troubled by these statistics, Congress requested in 2003 that the Institute Of Medicine (IOM) study the frequency of medication errors and formulate a national agenda to reduce its prevalence.

The IOM found that medication errors are even more common than previously thought, and extremely costly to the U.S. health care system. The report suggests many areas for change, including a shift in the patient-provider relationship, increased use of information technology, improved medication labeling and packaging, as well as several policy initiatives.

New health care model. The IOM report suggests that the best way to reduce medication errors is to create a new model of health care whereby patients take a more active role in learning about and monitoring their own medications. For example, health care professionals should encourage patients to ask questions, keep a record of current medications and report unexpected adverse events to their doctor. In turn, doctors, nurses and pharmacists should take the time to educate patients about medications, including any risks, contraindications, or side effects associated with the drug's use. Additionally, the report recommends that the Food and Drug Administration, the National Library of Medicine and other government agencies work together to update patient medication information leaflets and develop a 24-hour hotline for easy access to drug information.

Information technology. The IOM also found that medication errors would be reduced if health care professionals made greater use of information technology in prescribing and dispensing medication. In particular, the widespread implementation of e-prescribing could potentially reduce medication errors significantly. For instance, e-prescribing would all but eliminate mistakes caused by hard-to-read handwritten prescriptions. Furthermore, if e-prescribing were tied to a patient's medical history, doctors could check automatically for allergies, drug interactions and correct doseages. Based on its findings, the report recommends that all prescribers and pharmacies develop a plan to transition to e-prescribing by 2008 and have the systems up and running by 2010.

The drug industry. A portion of medication errors occur because certain drug products have similar names or packaging. Therefore, the report suggests that the drug industry and appropriate federal agencies work together to improve the names, abbreviations and acronyms of medications, along with accompanying drug information sheets. The report also recommends that the federal government fund and develop a research effort to learn more about how to prevent medical error, and that accreditation agencies require more training on medication management. ■

IOM Report: Preventing Medication Errors, July 2006.

On The Front Lines

Protecting tax-exempt health care organizations from IRS attack: Fifth Circuit rules against imposition of "intermediate sanctions"

by Albert Y. Lin, Esq., Contributing Editor

This two part article offers an in-depth analysis of the recent decision in the closely-watched tax case, Caracci v. Commissioner,[1] in which the United States Court of Appeals for the Fifth Circuit set forth a very detailed summary of key facts that helped a tax-exempt home health agency fend off enormous IRS penalties assessed upon it following a conversion to a for-profit health agency. Compliance officers should use the Caracci case as an example of how critical careful documentation and proper valuations can be in tax-exempt transactions. Part 1 provides an overview of the remedies available to the IRS in policing tax-exempt organizations and discusses the events that lead to the Fifth Circuit's decision. Part 2 analyzes the Fifth Circuit's reversal and highlights the compliance lessons to be learned from the case.

The Internal Revenue Service (IRS) has made no secret of its increased scrutiny of tax-exempt health care organizations in recent years. A primary weapon in the IRS enforcement arsenal is the "intermediate sanctions" series of monetary penalties that may be assessed against a tax-exempt organization that confers what the IRS finds to be an "excess benefit" on key persons within a tax-exempt organization.

The increased financial pressure on tax-exempt health care entities in the past decade has led to heightened business activity between tax-exempt entities and for-profit groups. While joint ventures are increasingly commonplace, in some cases, tax-exempt organizations have chosen to leave the constraints of tax-exempt status to obtain business opportunities unavailable for tax-exempt, charitable health organizations. The conversion from an exempt to a for-profit entity is not without pitfalls because by law, the net earnings of a tax-exempt, charitable organization may never inure to the benefit of a private individual. Violations of this rule leads to severe tax penalties. In this type of conversion transaction, as well as any other transaction with for-profit entities, the charitable organization needs to carefully document its arms'-length nature.

IRS weapons: Intermediate sanctions and revocation of tax-exempt status

Many health care organizations are exempt from federal income tax under section 501(c)(3) of the Internal Revenue Code of 1986, as amended (Code). Exempt organizations qualifying under this particular Code section are also known as "charitable organizations" or more generally as "section 501(c)(3) organizations." As a condition of their exemption from federal income taxes, these entities cannot be *organized or operated for the benefit of private interests.*

More specifically, section 501(c)(3) of the Code provides that "no part of the net earnings ... [may] inure to the benefit of any private shareholder or individual."[2] From this provision are drawn two legal requirements referred to as the "*private inurement*" and the "*private benefit*" prohibitions in federal exempt organizations law.

Private inurement relates to the situation in which the net earnings - the excess of funds over reasonable expenses - is redirected to persons, or persons related to such persons, who are essentially in control of the tax-exempt entity. These persons are termed "insiders." *Private benefit* is broader and encompasses situations in which the overall resources of the exempt organization may benefit general, rather than specific, outside parties (who do not have to be insiders). Private inurement is absolutely prohibited to any extent. In contrast, some insubstantial amount of private benefit may be permitted without jeopardizing the tax exempt status of the organization.

Because revocation of tax-exempt status is so severe, the IRS also has somewhat less severe, but still very material, penalties designed to force misbehaving section 501(c)(3) organizations into compliance. These are a series of monetary penalties called "intermediate sanctions." These penalties are called "intermediate" because they are imposed on certain persons rather than the organization itself.

The intermediate sanctions (also described as taxes on "excess benefit" transactions) penalize two key players in a section 501(c)(3) organization: any "*disqualified person*" or any "*organization manager*." A "*disqualified person*" includes:

(i) any person who was, at any time during the five-year period ending on the date of such transaction, in a position to exercise substantial influence over the affairs of the corporation;

(ii) a member of the family of a person described above; and

(iii) any entity in which any of the persons described above owns a 35 percent voting or beneficial interest.[3]

An "organization *manager*" means any officer, director, trustee, or any person with similar powers in the organization.

The penalties themselves work as follows.

1. *A penalty tax of 25 percent of an "excess benefit" is imposed on the disqualified person.*[4]An "excess benefit" arises if an economic benefit (i.e., cash or property) is provided by a tax-exempt organization directly or indirectly for the use of any disqualified person (i.e., the company President), and the value of the economic benefit exceeds the value the tax-exempt organization receives in exchange.[5]In other words, when a section 501(c)(3) organization gives a disqualified person compensation or goods, but receives something worth less in exchange, an excess benefit arises and it is potentially subject to intermediate sanctions.

"In this type of conversion transaction, as well as any other transaction with for-profit entities, the charitable organization needs to carefully document its arms'-length nature."

2. *If a 25 percent excess benefit tax is imposed as described above, another penalty tax of 10 percent on the excess benefit is imposed on any organization manager who participated in the transaction, unless the participation is not willful and due to reasonable cause.*[6] This tax is limited to $10,000 in the aggregate for each excess benefit transaction. If multiple organization managers are involved, they are each jointly and severally liable.

3. *An additional penalty tax of 200 percent of the excess benefit is imposed if the first 25 percent penalty tax was imposed and the excess benefit transaction is not corrected (i.e., the excess monies returned) within a certain period.*[7] Generally, the excess benefit identified must be corrected before the IRS issues a "notice of deficiency," which is a letter that does not arrive until well after the organization and disqualified person are aware of the exposure and/or investigation.

The taxpayer in *Caracci* spent six years dealing with the IRS in a protracted fight with enormous intermediate sanctions at stake because the IRS argued the transaction resulted in private inurement. The case, while victorious at this point for the taxpayer (the IRS could still request a rehearing or appeal to the Supreme Court), teaches all tax-exempt health care organizations valuable lessons.

The *Caracci* battle

Sta-Home Health Agency, Inc. and its two sister entities, Sta-Home Health Agency, Inc. of Forest, Mississippi and Sta-Home Health Agency, Inc. of Grenada, Mississippi (collectively, "Sta-Home") provided home health care in rural Mississippi. Organized by Joyce Caracci, a registered nurse, as nonstock, tax-exempt corporations, the entities obtained section 501(c)(3) status in the 1970s. Ms. Caracci believed Sta-Home would compensate for inadequate institutional care in the region. The vast majority of Sta-Home's revenues - 95 to 97 percent - came solely from Medicare and Medicaid reimbursements.

Reliance on governmental health reimbursements proved precarious for Sta-Home. In the mid-90s, Medicare reimbursed home health care agencies on a retrospective basis by paying a "periodic interim payment," or "PIP," every two weeks in addition to payment on claims submitted. Medicare adjusted the payments by reviewing the provider's annual cost report. If Medicare found any reported costs were unallowable, it would require repayment for those costs. This virtually eliminated any ability for Sta-Home to realize a profit. Despite increasing revenue from 1991 ($11.7 million) to 1995 ($44.1 million), as well as national goodwill (Sta-Home was accredited by the Joint Commission on Accreditation of Healthcare Organizations), losses simply increased.

During 1994 and 1995, Congress proposed to change Medicare reimbursement for many health care entities including home health agencies from the retrospective payment system based on costs to a prospective payment system based on rates. Concerned with the proposed system's impact on cash flow, Sta-Home consulted with an attorney, who recommended the entities convert to for-profit corporations. The conversion would enable Sta-Home to obtain access to lenders who were otherwise unwilling to extend credit to exempt organizations and otherwise potentially increase access to capital in other ways, such as raising capital by offering shares and reading the business for mergers and acquisitions, among others.

Thus, in October of 1995, each Sta-Home entity converted to a for-profit subchapter "S" corporation by first creating a for-profit corporation, followed by a transfer of all the assets of an exempt corporation to the for-profit corporation, in exchange for the assumption of all debts and liabilities of the former exempt corporation. Therein lay the primary issue. In this transaction, the former exempt organization must receive adequate consideration in exchange for the assets it transferred to the for-profit entity. All it received in exchange for the assets was the relief of its liabilities. Was this enough? If not, the shareholders of the new for-profit entities received an "excess benefit" because they acquired assets for less than

fair market value. Sta-Home, upon advice from tax counsel, obtained two appraisals for its assets and liabilities (in part because the tax counsel expressed concern that appraisals were not done for unrelated conversions proposed by Sta-Home's primary attorney).

The IRS audited Sta-Home in the late 90s and quickly issued "notices of deficiency" to the Sta-Home founders and agencies in 1999. The IRS explained that the assets transferred to the new for-profit corporations exceeded the transferred liabilities by $18.5 million. In other words, the exempt organizations should have received $18.5 million when they transferred the assets (and, conceptually, then used the $18.5 million for charitable purposes). Because this did not occur, the conversion transaction created an "excess benefit" to the Sta-Home founders of that amount. After the intermediate sanction penalties and accrued interest were applied, the Caraccis were faced with a gargantuan $256.1 million tax bill. The Caraccis naturally disagreed; and took the IRS to the tax court to argue their side.

Tax court fight

At the tax court, the battle began. Both sides brought forth new experts in valuation. At heart of the dispute was proper valuation. There are three basic valuation approaches: (1) *income* (which assigns value based on how much money the business generates in the future); (2) *cost (*which looks to how much it costs to replace the entity's tangible and intangible assets); and (3) *market* (which looks to comparable sales).

" After the intermediate sanction penalties and accrued interest were applied, the *Caraccis* were faced with a gargantuan $256.1 million tax bill."

In the IRS corner, its expert, a certified public accountant at a Portland consulting and valuation firm, rejected the cost method of valuation and applied a combination of the market and income approaches. His cost valuation began with observation of transfers of home health agencies from commercially-prepared surveys. One looked at values of comparable publicly traded agencies; the other at consideration paid for merged or acquired entities. His methods used "market value of invested capital" (MVIC) method, which look to the market value of a company's capital structure. The MVIC, it is argued, represents the invested capital of equity and liabilities that generate revenues. The MVIC market value is arrived by taking annual revenues of Sta-Home and applying to the MVIC a "revenue pricing multiple" that the expert derived from observation of the comparables. For the income approach, the IRS expert discounted a calculated stream of income that a purchaser could generate. A weighted average of two methods became the basis for his valuation that ultimately found that assets exceeded liabilities by $7 million.

In Sta-Home's corner, its expert, a director at PricewaterhouseCoopers, relied upon the cost approach because he felt the predominance of Medicare in the revenue stream made the income approach inappropriate. His valuation relied on an "adjusted balance sheet" method in which the entity's balance sheet would be restated to fair market value equivalents. This approach required identification and valuation of tangible and intangible assets and liabilities. His valuation included particular unrecorded liabilities for balance due to Medicare and allowances for future claims against the entities, as well as a reserve for future downward Medicare reimbursement adjustments. Then, to account for the retroactive nature of the valuation during litigation, the Sta-Home expert prepared a range of values. His ultimate conclusion found the combined liabilities of Sta-Home exceeded the combined values of assets by $500,000 to $2 million. He further corroborated this valuation by utilizing market comparables as a secondary indicator from his own sources; however, his method differed from the IRS expert's method in that he felt publicly traded comparables needed to be excluded.

The tax court ultimately rejected all of the Sta-Home experts' methods, and chose to apply its own assessment of value by applying its own arbitrary "revenue pricing multiple." Moreover, the tax court made its own adjustments to the MVIC amount - it chose to increase MVIC by adding current liabilities, increasing the MVIC and thus increasing the valuation. The tax court found that the conversion resulted in a $5.1 million "excess benefit," and ordered Sta-Home to pay penalties and interest of $69.7 million relating to intermediate sanctions. Not surprisingly, Sta-Home appealed the tax court decision to the Fifth Circuit.

Part 2 of this article will address in detail the Fifth Circuit's opinion in reversing the tax court's decision and outline the processes taken by Sta-Home that, in the court's opinion, were correct. Part 2 will also discuss compliance lessons.

Albert Y. Lin, Esq., an associate at Brown McCarroll LLP in Austin, Texas, practices in the firm's health care and tax groups representing tax-exempt and governmental hospital systems, ambulatory surgery centers, physician groups, and other health care providers. Albert has extensive experience with formation, structuring, and reorganization of tax-exempt entities. His prior background as a certified public accountant strengthens his understanding of tax and financial compliance aspects of his clientele. He represents such clients directly before the IRS and Department of Labor in tax and benefits matters. Along with Frank Sheeder, Esq. of Brown McCarroll LLP, Dallas, Texas, he co-authored several chapters in the CCH Health Care Corporate Governance Guide, which provides explanations and practical advice related to corporate compliance issues for tax-exempt health care organizations.

1 *Caracci v. Commissioner*, 2006 U.S. App. LEXIS 17370 (July 11, 2006), *rev'g* 118 T.C. 25 (2002).
2 I.R.C. § 501(c)(3); Treas. Reg. § 1.501(c)(3)-1(a)(1).
3 I.R.C. § 4958(f).
4 I.R.C. § 4958(a)(1).
5 *Id.* § 4958(c).
6 *Id.* § 4958(a)(2).
7 *Id.* § 4958(b).

Employer interference: Hospital restricts nurses from wearing union buttons

by Lisa Milam-Perez, Contributing Editor

A hospital did not unlawfully interfere with protected activity when it enforced a policy prohibiting employees from wearing a union button that read "RN's Demand Safe Staffing" in areas of the facility where patients or their families might be encountered. The restriction on this particular button was justified by special circumstances, a 2-1 majority of the National Labor Relations Board (NLRB) ruled.

The nurses donned the "safe staffing" buttons to support their position regarding current hospital staffing levels, which was a key bargaining subject in ongoing union negotiations with the hospital for a new contract. Because nurse managers feared the buttons would have a detrimental impact on patients and their families, their use was restricted to areas where patients and families would not see them. (Curiously, the hospital imposed no restrictions on buttons that read "Staffing Crisis," "Nursing Shortage," and "Medical Errors.")

Special circumstances. Bans on union-related buttons are presumptively valid in immediate patient care areas, however, the majority of the NLRB concluded the hospital showed that special circumstances existed to rebut the presumption of invalidity, demonstrating its prohibition was necessary to avoid disturbing patients or disrupting care.

One NLRB member, Liebman, rejected the finding of special circumstances based on what she deemed "mere speculation" that the button would cause a disturbance. She argued that the hospital's tolerance of the other buttons undercut its contention that the "safe staffing" button would interfere with patient care, noting "the nurses wore the button for months without incident."

It was not necessary to show actual disturbance of patients, according to the majority of the NLRB members; rather, the "reasoned judgment of health care professionals" was sufficient to establish a potential disturbance. "A hospital need not wait for the awful moment when patients or family are disturbed by a button before it may lawfully be restricted," the NLRB wrote.

Moreover, the hospital's long history of tolerating more innocuous buttons did not foreclose the employer from ever imposing restrictions, or lend support to the claim of unlawful interference; rather, it militated against such a finding. The majority of the NLRB members declined to second-guess the hospital's business judgment that the other buttons were not similarly disruptive.

"Contrary to our dissenting colleague we do not view the message on this button as a garden-variety union button," the majority concluded. "Rather, in the context of an acute-care medical facility, the button's demand that staffing be made safe sends a clear message to patients that their care is currently in jeopardy." Thus, special circumstances justified the narrow restriction. Accordingly, the NLRB reversed the administrative law judge's finding to the contrary and dismissed the complaint. ■

Sacred Heart Medical Center and Washington State Nurses Association, 347 NLRB No 48, June 30, 2006.

Hospital liable for overtime worked by agency nurse

by Lisa Milam-Perez, Contributing Editor

A nurse who worked exclusively at one New York hospital was an "employee" of the hospital within the meaning of the Fair Labor Standards Act although she was assigned there through staffing agencies, a federal district court in New York ruled. Thus, the hospital was liable for unpaid compensation for the overtime hours she worked at its facility.

The hospital argued that it was not her employer because the nurse was paid by three different nursing referral agencies; however, she was exclusively assigned to that hospital by all three agencies and she performed all of her work there. Applying a six-factor test, the court concluded the hospital was her "employer" within the meaning of the Act. It found that:

- the nurse performed her work on the hospital's premises, using the hospital's equipment;
- she worked exclusively for the hospital;
- the work she performed was integral to the hospital's operations;
- her work responsibilities remained the same, regardless of which agency had referred her on any given shift;
- the hospital had some control over her work hours; it set the work schedule and forwarded information about its staffing needs to the agencies and the hospital, on several occasions, asked the nurse directly to work double-shifts; and
- the hospital exercised at least some control over which agency nurses would be assigned to their facility; it regularly evaluated agency nurse performance and could prohibit an agency nurse from working there if it was dissatisfied with his or her performance.

The hospital then argued it should not face liability even if it was found to be an employer. It claimed that it was prevented from determining how many hours the nurse actually worked at the facility because she signed in through multiple referral agencies. The court, however, rejected this defense. "It is undisputed that [the nurse] accurately reported all of the hours she worked on the appropriate agency sign-in sheets, and that [the hospital] collected these sign-in sheets and cross-referenced them on a daily basis against verification forms that supervising nurses signed after each shift," the court noted.

Because it was clear the hospital exercised functional control over the nurse and was her joint employer, summary judgment was granted in her favor. Moreover, she was awarded liquidated damages because the hospital took no affirmative action to ensure that its actions, and its stance that it was the staffing agencies that were responsible for paying her overtime, were compliant with the Act. ■

Barfield v NYC Health and Hospitals Corp, 05 Civ. 6319 (JSR), SDNY, May 30, 2006.

Information Tech

Executive order requires agencies to share information on prices and quality

by Catherine Hubbard, M.A., Contributing Editor

President Bush on August 22, 2006, signed an executive order to make health care prices more transparent and quality information more available. The executive order directs four federal agencies: the Department of Health and Human Services, the Defense Department, Veterans Affairs, and the Office of Personnel Management, to share with beneficiaries information about prices and quality of services.

The order also directs the agencies to use improved health IT systems to facilitate the exchange of health information and directs agencies to develop and identify approaches that facilitate high quality and efficient care, according to a White House fact sheet. In addition, it requires agencies and their health care contractors to promote the use of interoperable health information technology products, so that data can be easily shared.

"This executive order is about changing the system by using the purchasing power of the federal government to begin to shape the market in conjunction with other payers," said HHS Secretary Michael Leavitt at a briefing. He said the change is needed because few people know what their health treatments cost and understand the quality that they're receiving as it relates to other alternatives, he said.

Chip Kahn, president of the Federation of American Hospitals, said the executive order is an important step toward achieving value-base information for consumers and patients and will provide hospitals and physicians with important benchmarks that they can use to improve health care services. "We hope that it will lead to greater standardization in reporting quality measures and spur the development of important health information technology," he said. ■

CCH Washington Bureau, August 23, 2006.

In the News

Medi-Cal has record year for fraud recovery

California Attorney General Bill Lockyer announced on August 16, 2006, the state Department of Justice's Bureau of Medi-Cal Fraud and Elder Abuse (BMFEA) in fiscal 2005-06 won a record-shattering $274.4 million in court-ordered recoveries of funds fraudulently taken from the Medi-Cal program. The BMFEA investigates and takes enforcement action against health care providers and others who defraud Medi-Cal by overbilling, billing for non-existent or unneeded services or products, or pay or receive kickbacks for referrals. Since Lockyer became Attorney General in 1999, court-ordered recoveries in Medi-Cal fraud and elder abuse enforcement actions totaled $512.1 million. That is $433.2 million more than the $78.9 million obtained during the previous 20 years put together.

California Attorney General Press Release, August 16, 2006.

OIG announces state FCA guidelines

As required under Section 1909 of the Social Security Act, the Office of Inspector General has published guidelines for state false claims laws. For states to receive a 10 percent increase in Medicaid fraud recoveries, they must enact a state false claims act that (1) establishes liability to the state for false or fraudulent claims described in 31 U.S.C. §3729; (2) contains provisions that are at least as effective in rewarding and facilitating qui tam actions for false or fraudulent claims as those described in 31 U.S.C. §§3730–3732; (3) contains a requirement for filing an action under seal for 60 days with review by the State Attorney General; and (4) contains a civil penalty that is not less than the amount of the civil penalty authorized under 31 U.S.C. §3729. A state must have the law in effect by January 1, 2007, to be considered in compliance. States may choose not to enact false claims acts, or may choose to enact false claims acts that do not meet the enumerated requirements. However, a state that does not have such a law in effect will not qualify for the 10 percentage point increase in its share of any recoveries from an action brought under such a law.

Notice, 71 FR 48552, August 21, 2006, Health Care Compliance Reporter, ¶760,063.

Grassley asks CMS to explain erroneous Medicare refunds

In a letter to CMS administrator Mark McClellan regarding the recent erroneous refunds of Medicare Part D premiums, Senator Grassley (R-Iowa) urged Medicare officials to seek repayment from beneficiaries "in increments that are manageable for beneficiaries." In CMS correspondance to beneficiaries, however, CMS gave the option of sending a check or money order for the full amount of the refund or having their personal bank accounts debited. A CMS computer error caused approximately 230,000 beneficiaries to erroneously receive refunds of their Medicare Part D premiums that will need to be recovered by Medicare. Grassley also asked for a report detailing how this error occurred, what action the agency is taking to remedy this error, and how it will address any systemic issues that may be involved to ensure that similar errors do not happen in the future.

Grassley Press Release, August 23, 2006, CMS Letter to Beneficiaries, August, 2006.