Farrell Fritz, P.C.

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Welcome!

We wish our readers a safe and enjoyable summer.

In recent months, the IRS, the Office of the Medicaid Inspector General, and the Department of Health and Human Services have each issued documents related to various compliance and disclosure requirements for healthcare providers. Clearly, the intent is to hold providers increasingly accountable for their policies and procedures. This issue provides an update on three of the current developments.

As always, please feel free to contact us with your comments, questions and suggestions about topics that are of particular concern or interest to you. We welcome your feedback.

Christopher J. Kutner, Esq.
Michael E. McDermott, Esq.

Inside

Non-Profits Face Sweeping New Disclosure Requirements Under 2008 IRS Form 990

By Michael E. McDermott, Esq.

Not-for-profit hospitals must now be prepared to make highly detailed disclosures of practically every aspect of their operations, under new Internal Revenue Service regulations.

The IRS released the final 2008 Form 990 in December 2007 and issued the draft instructions accompanying the new Form on April 7, 2008. The new Form 990 and the draft instructions require not-for-profit organizations to give detailed information about conflicts of interest, executive compensation practices, charity care and community benefit practices, conversions, governance practices, use of subsidiaries, and joint ventures.

The new Form 990 asks if hospitals have adopted numerous policies and procedures, including: Conflicts of Interest Policy; Whistleblower Policy; Document Retention and Destruction Policy; Audit Committee Charter; Policy on Compilations, Reviews, and Audits; Policy Requiring Safeguarding Exempt Status with Respect to Transactions and Arrangements with Related Organizations; Community Benefit Report; Charity Care Policy; Billing and Collection Policy; and Executive Compensation Policy. Here are some additional details on several key areas:

Conflicts of Interest

The Conflicts of Interest Policy questions are a clear attempt by the IRS to determine if there are any direct or indirect relationships with board members, officers, and key employees that could give rise to conflict of interest transactions.

The IRS wants to know the percentage of employees receiving more than $100,000 per year, with the highest paid person listed on the front page of the Form. For every person receiving more than $150,000 in cash or $250,000 in total compensation, the organization must provide detailed information including whether the compensation includes loans, nonqualified deferred compensation, non-taxable fringe benefits, or reimbursement for first-class travel, club dues, or personal residences. The executive compensation reporting must show that it was approved by independent members of the board, based on comparable data, and was substantiated contemporaneously in the board minutes.

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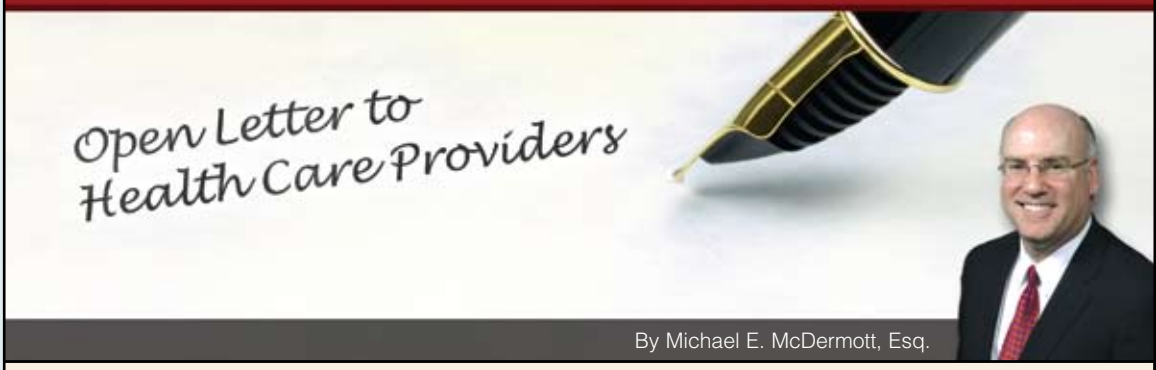
Farrell Fritz PROFILES

As in previous issues, we'd like to introduce readers to another of our colleagues who can assist health care clients with a variety of business-critical issues:

Domenique Camacho Moran, commercial litigation partner, leads the labor and employment practice group at Farrell Fritz. She represents employers, including health care providers and related not-for-profit organizations, in all types of employment matters arising under federal and New York State law. Domenique conducts training and counsels employers on the practical and legal implications of everyday employment decisions. She prepares and reviews personnel policies, negotiates employee severance agreements and counsels employers on staff reorganizations and workforce reductions.

Domenique can be reached at dmoran@farrellfritz.com.

OIG Streamlines Self-Disclosure Requirements for Healthcare Providers



By Michael E. McDermott, Esq.

The Department of Health and Human Services Office of Inspector General's ("OIG") April 15 Open Letter to Health Care Providers refines the requirements of the OIG Provider Self-Disclosure Protocol ("SDP"), under which healthcare providers can voluntarily report fraudulent conduct affecting Medicare, Medicaid, and other federal healthcare programs. In case you haven't seen it, here's a synopsis:

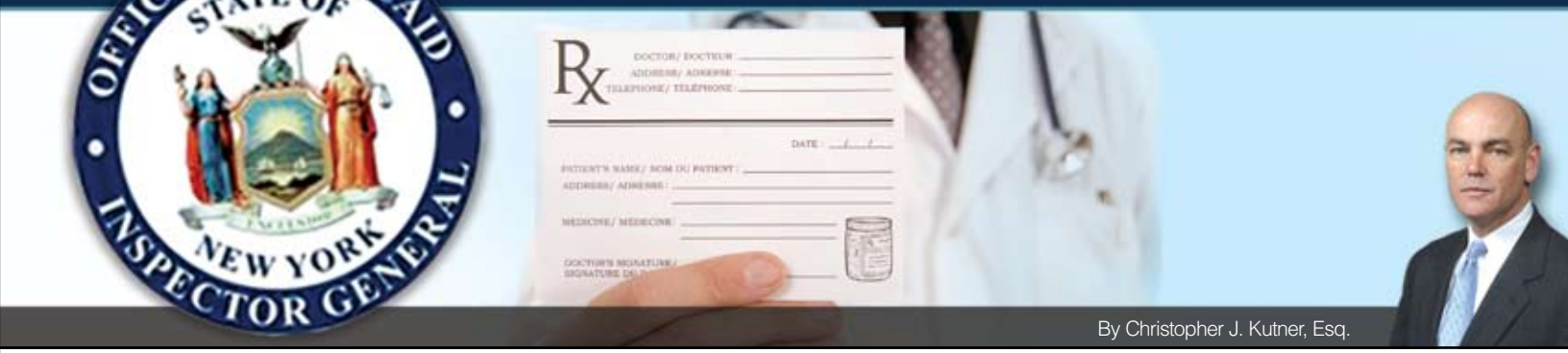
The letter notes that the OIG has streamlined its processes for resolving SDP cases. The OIG stated, "[a] provider's submission of a complete and informative disclosure, quick response to OIG's requests for further information, and performance of an accurate audit are indications that the provider has adopted effective compliance measures."

According to Inspector General Daniel Levinson, when the OIG negotiates the resolution of its "applicable administrative monetary and permissive exclusion authorities in exchange for an appropriate monetary payment," it generally will not require the provider to enter into a Corporate Integrity Agreement or Certification of Compliance Agreement.

The OIG further explained in the letter that "[d]isclosures that are characterized as mere billing errors or overpayments are not appropriately addressed by the SDP and should be submitted directly by the provider to the appropriate claims-processing entity, such as the Medicare contractor."

The open letter also sets forth four additional submission requirements: (1) a complete description of the conduct being disclosed; (2) a description of the provider's internal investigation or a commitment regarding when it will be completed; (3) an estimate of the damages to the federal healthcare programs and the methodology used to calculate that figure or a commitment regarding when the provider will complete such estimate; and (4) a statement of the laws potentially violated by the conduct.

OMIG Work Plan Strengthens Focus on Medicaid Waste, Fraud and Abuse



By Christopher J. Kutner, Esq.

Many healthcare organizations may not be familiar with the Office of the Medicaid Inspector General ("OMIG"), a relatively new agency that coordinates Medicaid fraud, waste and abuse control activities of all of the state executive branch agencies and makes recommendations to the legislature on program improvements. With the release of OMIG's first official work plan on April 8, 2008, let me provide some background on this agency and its potential impact on your business.

Role of OMIG

Established in November 2006, OMIG's role is to audit, investigate and detect fraud and recover state funds that have been inappropriately claimed by healthcare providers and individuals. In the event OMIG identifies activities that may be criminal in nature, it refers those matters to the Office of the Attorney General of New York, which determines whether to prosecute.

Recovery Benchmarks

OMIG's efforts are funded more than half by the Centers for Medicare and Medicaid Services ("CMS") of the Department of Health and Human Services. The federal CMS funding resulted from an agreement New York made with CMS in 2006, which requires New York to achieve certain benchmarks for recoveries each year. The recovery amount New York committed for Federal Fiscal Year 2008 is $215 million. OMIG is using various methods to meet the goal. For example, OMIG has entered into demonstration projects with certain counties, entered into agreements with contractors with experience in audit and recoveries, and is collaborating with various agencies in New York State to broaden the reach and identification of recoveries.

Outlook of Leadership

I recently had the opportunity to meet with New York's MIG, James Sheehan, who was appointed by former Governor Spitzer. In our discussion, he identified some of OMIG's targets for its recovery efforts, which include hospitals (e.g., same-day readmissions); managed care companies (inappropriate kick payments and/or duplicate payments); home health care agencies, pharmacies and pharmaceutical companies; and diagnosis and treatments centers.

One thing was very clear to me: the MIG is quite capable, experienced and well versed in his area. It was obvious from meeting him that Mr. Sheehan will use all available resources and technology to detect areas of possible fraud, waste and abuse. With $48 billion budgeted for the Medicaid program in New York for 2008, this year may provide recoveries from the "low hanging fruit," but as the dollar amount New York State commits to CMS for recoveries increases in future years, so will the aggressiveness of the OMIG.

Developing a Culture of Compliance

For healthcare providers and suppliers to the Medicaid program, an effective compliance program is paramount. A nicely written and bound document entitled "Compliance Manual" will not suffice if compliance is not inbred in the culture of the organization. All employees should be trained on how compliance affects their areas of responsibility and know that they must speak up if they believe a claim should not be submitted or reimbursement should not be retained. The OMIG will not tolerate complacency. It demands an active compliance program with which every level of the organization is involved.

The Medicaid healthcare business is highly complex. It is incumbent upon every individual/entity receiving Medicaid reimbursement dollars to be ever so diligent and vigilant in their processes. When an overpayment is received it must be immediately refunded to the Medicaid program. Every dollar must be utilized appropriately. OMIG will not tolerate sloppy or deficient record keeping. If an individual/entity does not have meticulous records to justify the Medicaid reimbursement received, OMIG will demand a refund. There will be much to write about this topic in the coming months and years. We will be following Mr. Sheehan's efforts very closely.

Welcome to THE FIRM

Farrell Fritz welcomes the following attorneys who have recently joined the firm.

Norma B. Levy, litigation counsel; **Michael P. Stafford**, trusts & estates counsel; **Suzanne Q. Burke** and **Jordan S. Linn**, trusts & estates associates; **Heather P. Harrison** and **Jonathan M. Kashimer**, litigation associates; and **Lia M. Pistilli**, corporate associate.

KUDOS

Congratulations to commercial litigation partners **John P. McEntee** and **Domenique Camacho Moran**. John was named to *Super Lawyers'* National "Top Attorneys in Business Litigation" list. Domenique was honored by *The Queens Courier and Queens Business Today* at the 2008 Top Women in Queens awards dinner.

New Non-Profit Disclosure Requirements...continued from page 1

Charity Expenditures

Hospitals will also be required to report charity care and community based expenditures in several categories, including charity care at cost, unreimbursed Medicaid, health professions education, research, and cash-in-kind contributions.

Asset Conversions

The new Form includes a section requiring organizations to report the liquidation, dissolution, or termination of the organization or the disposal of significant assets. This requirement addresses concerns the IRS has when directors and officers become directors or officers of conversion foundations or owners of successor organizations.

The new Form 990 resembles a disclosure document more than a tax form, and is further proof of the trickle down effect of Sarbanes-Oxley. Hospitals must be mindful that the Form is a public document and will now be a convenient way for regulators and legislators to obtain detailed information that was until now otherwise generally unavailable.

How to Prepare?

Hospitals should consider taking a risk management approach to the new Form, including monitoring potential disclosures, taking an inventory of corporate policies and procedures and reviewing and revising them on a regular basis, and preparing a mock Form 990 in advance of the initial reporting date. By taking these steps, hospitals can avoid potential adverse tax and public relations consequences.

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