

The Financial Diagnosis

FEBRUARY 2012

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Letter from the President

I would like to officially wish all of our members a Happy New Year. I can't believe 2012 is upon us and my tenure as your President is down to a few short months.

In my last message I asked for your help...and you delivered! We recently received the results of the annual Membership Satisfaction survey. Our goal, as set by National, was for at least 55% of responses to be in the "very satisfied" or "extremely satisfied" categories. With your help, we were able to achieve 64% in these categories, which is 3% higher than the prior year. Special thanks to all those who took time to provide us with your feedback. For those of you who were less than very satisfied, we will use your comments to continue to improve your membership experience.

On Friday, January 20th, we held the Winter Institute at Churchill Downs.

This was our first attempt at collaborating with the Kentucky Chapters of the American College of Healthcare Executive (ACHE) and the National Association of Health Services Executives (NAHSE). The results were outstanding with approximately 200 folks in attendance. I want to thank everyone who was involved in the planning for this event, as well as ACHE and NAHSE for agreeing to participate. Job well done!!

Since our members play such a significant role in helping us achieve our goals, I feel it's appropriate to keep you apprised of our progress. In the last newsletter I provided a report card through October 2011. I would like to take this opportunity to update that report card through January 31st. I am pleased to report that we are still tracking very nicely toward our targets. The table below depicts where the Chapter stands in relation to our goals as of January 31st.

| Metric | Goal | Estimated - 1/31/11 | Progress |
|-------------------------|---------------------------------|---------------------|-----------|
| Education Hours | 8,307.0 | 6,975.0 | (1,332.0) |
| Membership | 590 | 552 | (38) |
| Certified members | 7.9% | 8.0% | .1% |
| Days cash on hand | 150-600 days | 314 days | Achieved |
| Membership satisfaction | 55% very or extremely satisfied | 64% | Achieved |

As you can see, we have already achieved two of our major goals. The Chapter remains financially viable with favorable days cash on hand and generally speaking, our members are satisfied with the value they receive from their membership. With three months to go, we are approximately 84% of the way toward our education hours goal. The Spring Institute is scheduled for March 22nd and 23rd in Lexington. If history is any indicator this event should provide us with plenty of hours to achieve this goal by a reasonable margin.

The membership goal remains a concern. We are approximately 38 members short as of January 31st. However, we are not alone. Chapters across the country are experiencing similar membership trends. Economic cutbacks and provider consolidations are meaning fewer new members are joining and more historical members are not renewing. The Chapter leadership is not satisfied with meeting all but one goal. If you were paying attention to previous Chapter correspondence, you will recall we announced a Member-Get-A-Member drive that ran through the end of December. I would like to congratulate our winner, Tom Hales of Crittenden Health System. We appreciate Tom's efforts in recruiting new members and he will be rewarded with a \$250 gift card. In an effort to meet the membership goal, we are announcing a second Member-Get-A-Member drive that will run through the end of February 2012. If you refer and new member, be sure they list you as their sponsor and your name will be entered into a drawing for a \$250 gift card. The winner will be announced at our Spring Institute.

I want to thank you for all that you do to make this organization great. I look forward to seeing everyone at the Spring Institute.

Chris Woosley - President
Kentucky Chapter - HFMA
2011-2012



Legal Challenges to the Affordable Care Act

An HFMA Web Extra

Update: Supreme Court Grants Review of Healthcare Law Changes

The Supreme Court has granted review of four issues from challenges to the Affordable Care Act that have been pursued in the federal courts since passage of the Act in March 2010. The Court has set aside 5 1/2 hours for oral argument (arguments at the Court are typically restricted to one hour, with each side granted a half hour of argument). The four issues on which the Court has granted review are:

- The constitutionality of the individual mandate, requiring most Americans to purchase health insurance by 2014 (2 hours of argument)
- Whether the individual mandate is severable (if it is found to be unconstitutional, or whether the entire Act would have to fail (90 minutes of argument)
- Whether the Anti-Injunction Act prevents challenges to the Affordable Care Act at this time (1 hour of argument)
- Whether the Affordable Care Act's expansion of the Medicaid program is constitutional (1 hour of argument)

The first two issues--on the constitutionality and severability of the individual mandate--have attracted the most attention in litigation and review in the federal district and appellate courts. The possibility that the Anti-Injunction Act might bar challenges to the Affordable Care Act has also emerged as a significant issue, hinging on the question of whether the penalty for failure to observe the individual mandate functions as a tax.

The argument that the Act's expansion of Medicaid is unconstitutional has not been successful in lower court challenges. This argument asserts that the Act violates the Constitution's Spending Clause (Article I, Sec. 8, Clause 1), based largely on speculation in preexisting Supreme Court case law that financial inducements offered by Congress to encourage state action could at some point pass a threshold and become coercive.

An Overview of Challenges to the Affordable Care Act

Opponents of the Affordable Care Act have turned to the federal courts to challenge the constitutionality of the legislation. The focus of the litigation is on the "minimum essential coverage" provision in Sec. 1501 of the Act. This provision—commonly known as the "individual mandate"—requires that virtually all legal residents of the United States obtain minimum essential health insurance coverage for each month, starting in 2014, or pay a penalty that will be included with the individual's federal tax return.

Although challenges to the law have deployed a wide range of constitutional arguments, the most attention has been given to these four issues:

- Whether the individual mandate is a permissible exercise of Congress's powers under the Commerce Clause in Article 1 of the Constitution
- Whether the individual mandate is permissible under Congress's powers to tax for the general welfare in Article 1 of the Constitution
- Whether the individual mandate is permissible under the Necessary and Proper Clause in Article 1 of the Constitution
- Whether—if the individual mandate is an impermissible exercise of Congress's power—the mandate can be "severed" from the Affordable Care Act, leaving the rest of the Act's provisions intact

The summary of these issues below draws from decisions in six federal district courts that have issued opinions on the constitutionality of the Affordable Care Act. These decisions are now making their way up through the federal appeals system; updates on rulings from the appellate courts are provided on the following page.

The Individual Mandate and the Commerce Clause

Article 1, Sec. 8, of the U.S. Constitution gives Congress the power "to regulate Commerce . . . among the several States." The Supreme Court has held that this clause gives Congress power over three general regulatory categories:

1. Regulation of the channels of interstate commerce
2. Regulation and protection of the instrumentalities of interstate commerce and of persons or things in interstate commerce
3. Regulation of activities that substantially affect interstate commerce

All of the courts that have considered the constitutionality of the individual mandate agree that the focus in this case is on the third category: regulation of activities that substantially affect interstate commerce.

The Supreme Court has also held that the proper focus is not on the actual impact of individual instances of the regulated activity on interstate commerce. Instead, the question is whether Congress had a rational basis for determining whether the regulated activities, taken in their aggregate, have a substantial impact on interstate commerce. Thus, for example, Congress had the authority to prohibit the possession of home-grown marijuana intended for personal use only—even for medical purposes permitted under state law—because, taken in the aggregate, personal growth and consumption of marijuana could have a substantial impact on an established and lucrative (albeit illegal) interstate market in marijuana (see *Gonzales v. Raich*, 545 U.S. 1 (2005)).

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Federal District Court Opinions

The six district court decisions that have addressed the merits of constitutional challenges to the Affordable Care Act include:

- *Thomas More Law Center v. Obama* (U.S. District Court, Eastern District of Michigan), upholding the constitutionality of the individual mandate under the Commerce Clause in an opinion by Judge George Caram Steeh.
- *Liberty University, Inc. v. Geithner* (U.S. District Court, Western District of Virginia), also upholding the constitutionality of the individual mandate under the Commerce Clause in an opinion by Judge Norman K. Moon.
- *Commonwealth of Virginia v. Sebelius* (U.S. District Court, Eastern District of Virginia), striking down the individual mandate as an unconstitutional exercise of congressional power, and severing the individual mandate and penalty from the Affordable Care Act (leaving the rest of the Act intact) in an opinion by Judge Henry E. Hudson.
- *State of Florida v. U.S. Department of Health and Human Services* (U.S. District Court, Northern District of Florida), which has ruled in an October 14, 2010 opinion by Judge Roger Vinson that the individual mandate and penalty cannot be considered a tax within Congress's constitutional powers of taxation. In a January 31, 2011 opinion, Judge Vinson also struck down the individual mandate as an unconstitutional exercise of congressional power and ruled that the individual mandate cannot be severed from the remainder of the Act.
- *Mead v. Holder* (U.S. District Court, District of Columbia), upholding the constitutionality of the individual mandate under the Commerce Clause in an opinion by Judge Gladys Kessler.
- *Goudy-Bachman v. U.S. Department of Health and Human Services* (U.S. District Court, Middle District of Pennsylvania), striking down the individual mandate and severing it and related Affordable Care Act clauses restricting insurers in an opinion by Judge Christopher Conner.

What are the limits on Congress's power to regulate interstate commerce? In two decisions over the past two decades, the Supreme Court has drawn a line at what it saw as Congress's efforts to regulate non-economic activity. In *United States v. Lopez*, 514 U.S. 549 (1995), the Court struck down Congress's effort under the Commerce Clause to prohibit possession of a firearm within a school zone as an attempt to regulate what was essentially non-economic activity. Similarly, in *United States v. Morrison*, 529 U.S. 598 (2000), Congress's attempt under the Commerce Clause to provide a federal civil remedy for victims of gender-motivated violence was struck down as an attempt to regulate non-economic activity.

The focus of the Affordable Care Act cases has been on how to characterize the decision not to purchase insurance coverage. The government argues that the healthcare market is unique in that no one can permanently "opt out" of the market. The question comes down to how an individual decides to pay for the expenses that will inevitably be incurred in that market: through health insurance, out-of-pocket payment, or uncompensated care that is funded by third parties through cost-shifting in the healthcare market.

The three judges who have upheld the constitutionality of the individual mandate agree. Individuals who choose not to purchase health insurance are making an economic decision that, taken in the aggregate, has a substantial impact on the healthcare market. As Judge Steeh wrote, "far from 'inactivity,' by choosing to forgo insurance plaintiffs are making an economic decision to try to pay for health care services later, out of pocket, rather than now through the purchase of insurance, collectively shifting billions of dollars . . . onto other market participants" (see *Thomas More Law Center v. Obama*).

Those who are challenging the individual mandate disagree. Two of the judges argue Supreme Court precedent on the Commerce Clause requires an economic activity for Congress to regulate, and "activity" requires some form of voluntary action. In the marijuana case discussed above, for example, individuals voluntarily acted in growing marijuana for personal consumption. The Affordable Care Act's individual mandate, by contrast, "compels an unwilling person to perform an involuntary act and, as a result, submit to Commerce Clause regulation." Judge Hudson agreed, finding no power under the Commerce Clause for Congress "to compel an individual to involuntarily enter the stream of commerce by purchasing a commodity in the private market" (see *Commonwealth of Virginia v. Sebelius*). Judge Vinson also found that the constitutionality of the mandate depends upon whether a decision not to buy health insurance can be considered an "activity" and concluded that "the individual mandate seeks to regulate economic inactivity, which is the very opposite of economic activity" (see *State of Florida v. U.S. Dept. of Health and Human Services*, Jan. 31, 2011 decision). Judge Conner, however, rejects the activity/inactivity distinction, placing significance instead on the Affordable Care Act's attempt to engage in "anticipatory regulation." No existing Supreme Court precedent, he argues, has involved a requirement to pay in advance for conduct that has not yet occurred.

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Judge Vinson also disagreed in his January 2011 opinion with the argument that health care represents a “unique” market. “Uniqueness is not an adequate limiting principle [with respect to Congress’s Commerce Clause powers] as every market problem is, at some level and in some respects, unique,” he wrote. “If Congress asserts power that exceeds its enumerated powers, then it is unconstitutional, regardless of the purported uniqueness of the context in which it is being asserted.”

The Individual Mandate and Congress’s Powers to Tax

As an alternative to Commerce Clause authority for the individual mandate and penalty, the government also cites Congress’s broad powers “to lay and collect Taxes, Duties, Imposts and Excises, to . . . provide for the . . . general welfare of the United States” (U.S. Constitution, Article 1, Sec. 8).

The tax argument is important for two reasons. First, as noted above, it is an alternative source of congressional authority to enact the individual mandate and penalty. Second, it provides the government with an argument that, under the Anti-Injunction Act, challenges to the individual mandate at this time are barred. The Anti-Injunction Act provides that “no suit for the purpose of restraining the assessment or collection of any tax shall be maintained in any court by any person, whether or not such person is the person against whom such tax was assessed.”

Two of the courts that have upheld the constitutionality of the individual mandate did not find it necessary to consider Congress’s power to impose the individual mandate and penalty under its tax authority, as they had already found that Congress had full authority to act under the Commerce Clause. Neither of these courts, however, agreed with the government’s argument that suits were barred under the Anti-Injunction Act. In *Thomas More Law Center v. Obama*, Judge Steeh held that the government had no authority to apply the Anti-Injunction Act to bar a lawsuit when no attempt to collect had been taken by the IRS. And in *Liberty University, Inc. v. Geithner*, Judge Moon noted that not once in its “lengthy statutory findings” on the individual mandate “does Congress indicate that it was exercising its taxing authority to impose the penalties.” Concluding that exactions imposed for violating the individual mandate were better characterized as regulatory penalties, not taxes, Judge Moon held that the Anti-Injunction Act did not apply.

Three courts have explicitly ruled that the individual mandate and penalty are not authorized by Congress’s taxation powers. Judge Vinson has ruled that it is inarguably clear that Congress did not intend the penalty to be a tax, for the following reasons:

- Language in earlier versions of the legislation that had described the penalty as a tax were stripped from the final version
- Congress relied exclusively on the Commerce Clause authority for the individual mandate and penalty
- The penalty was exempted from all traditional enforcement and collection methods (such as tax liens) used by the IRS
- There was no mention of a revenue-generating purpose for the penalty

Judge Vinson noted that there may have been political reasons for Congress to avoid using the word “tax” to describe the penalty, but “Congress should not be permitted to secure and cast politically difficult votes on controversial language by deliberately calling something one thing, after which the defenders of that legislation take an ‘Alice-in-Wonderland’ tack and argue in court that Congress really meant something else entirely” (see *State of Florida v. U.S. Department of Health and Human Services*, October 14, 2010 opinion).

Judge Hudson also held that Congress made a conscious choice in labeling the penalty imposed for failure to follow the individual mandate as a penalty rather than a tax. Citing Supreme Court precedent, Judge Hudson noted that “penalty” and “tax” are not synonymous, and something that is clearly a penalty “cannot be converted into a tax by the simple expedient of calling it such.” If something is a penalty, not a tax, it must be linked to an enumerated power of Congress other than the General Welfare clause, and Judge Hudson had already ruled that there was no valid link to Congress’s Commerce Clause authority (see *Commonwealth of Virginia v. Sebelius*).

Although Judge Kessler granted the government authority to enact the individual mandate under the Commerce Clause, she ruled that the government could find no such authority for enactment in the General Welfare clause’s taxing powers, agreeing with the other courts that Congress did not intend the penalty for noncompliance with the individual mandate to be a tax.

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The Individual Mandate and the Necessary and Proper Clause

In addition to granting Congress a list of enumerated powers, Article 1 of the Constitution also grants Congress the power to “make all Laws which shall be necessary and proper for carrying into Execution the [enumerated powers] of Congress.”

In essence, the Necessary and Power Clause gives Congress the power to use a means not included within its enumerated powers to reach an end that is within its enumerated powers. From very early in U.S. history, the powers of Congress under the Necessary and Proper Clause have been interpreted broadly. In the Supreme Court’s 1819 decision in *McCulloch v. Maryland*, 17 U.S. 136, Chief Justice Marshall wrote: Let the end be legitimate, let it be within the scope of the Constitution, and all means which are appropriate, which are plainly adapted to that end, which are not prohibited, but consist with the letter and spirit of the Constitution, are constitutional.

Judge Hudson and Judge Vinson have both rejected Congress’s authority to enact the individual mandate and penalty under the Necessary and Proper Clause. Judge Hudson ruled that “because an individual’s decision to purchase—or decline to purchase—health insurance from a private provider is beyond the historical reach of the Commerce Clause, the Necessary and Proper Clause does not provide a safe sanctuary.” Congress’s authority under the Necessary and Proper Clause, Judge Hudson held, “may only be constitutionally deployed when tethered to a lawful exercise of an enumerated power” (see *Commonwealth of Virginia v. Sebelius*). Similarly, Judge Vinson held that “the Necessary and Proper Clause cannot be utilized

to ‘pass laws for the accomplishment of objects’ that are not within Congress’ enumerated powers” (*State of Florida v. U.S. Dept. of Health and Human Services*, Jan. 31, 2011 opinion). Judge Conner also rejected the government’s Necessary and Proper Clause arguments, noting the individual mandate functions as a “partial funding mechanism” not necessary to regulation of the broader market. Judge Kessler held that Congress could find authority to enact the individual mandate under both the Commerce Clause and the Necessary and Proper Clause.

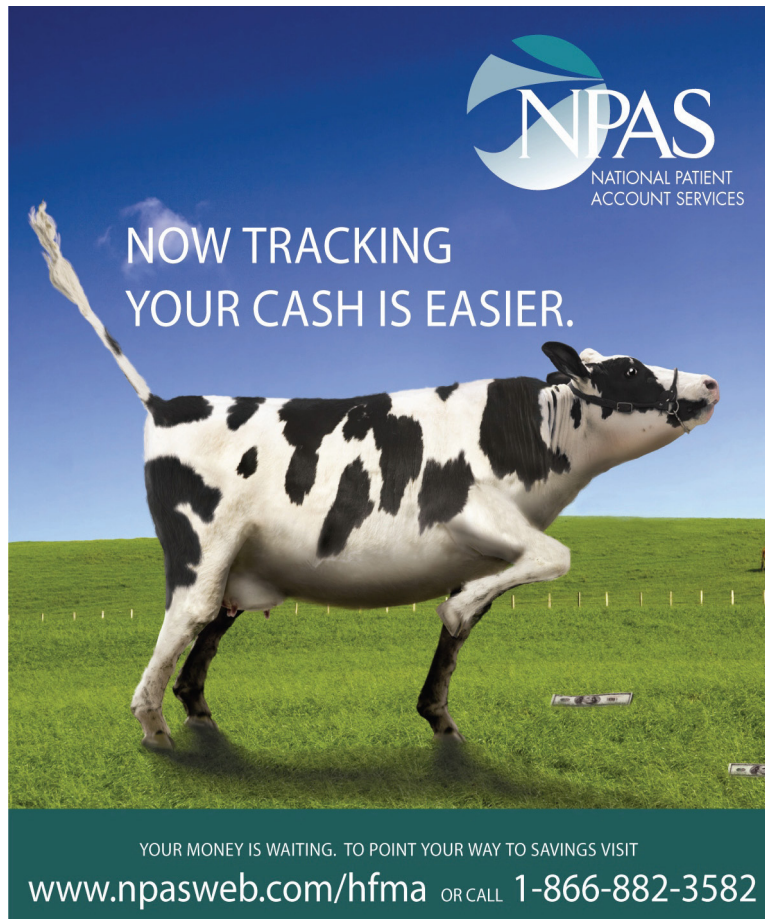
Severability of the Individual Mandate from the Affordable Care Act

The Affordable Care Act does not contain a severability clause. Severability clauses provide that the failure of one provision in an act of Congress does not affect the remaining portions of the act. The absence of a severability clause does not mean that provisions are not severable, but it can leave the decision regarding severability up to the courts. Only those judges who have struck down the individual mandate have had to address the severability issue.

Judge Hudson ruled that the individual mandate was a severable provision and the remainder of the Affordable Care Act would remain active (see *Commonwealth of Virginia v. Sebelius*). In so ruling, Judge Hudson cited the guidance of a Supreme Court precedent from the past year. In *Free Enterprise Fund v. Public Company Accounting Oversight Board*, 130 S. Ct. 3138 (2010), the Supreme Court said that “‘generally speaking, when confronting a constitutional flaw in a statute, we try to limit the solution to the problem,’ severing any ‘problematic portions while leaving the remainder intact.’” The key questions are whether the statute remains fully operative as a law with the violating provision removed, and whether it is evident that Congress would not have enacted the remaining provisions independently of the invalid provision.

Judge Conner also ruled that the individual mandate provision is severable, but added a twist. He noted that the individual mandate subsidizes both the “guaranteed issue” provision in the Act, preventing health insurers from denying coverage on the basis of pre-existing conditions, and the “community rating” provision, preventing insurers from varying rates based on location, gender, or health status. Because the individual mandate is “thoroughly intertwined” with these two provisions, they too must fail, although the rest of the Act remains valid.

Judge Vinson ruled that the individual mandate provision is **not** severable from the remainder of the Act. He noted that Congress “acknowledged in the Act itself that the individual mandate is absolutely ‘essential’ to the Act’s overarching goal of expanding the availability of affordable health insurance coverage and protecting individuals with pre-existing medical conditions.” Moreover, applying Supreme Court precedent from *Ayotte v. Planned Parenthood of Northern New England*, 546 U.S. 321, Judge Vinson held that, because the individual mandate could not be “cleanly and clearly” severed from many remaining provisions of the Act directly or indirectly affected



The advertisement features a black and white cow running in a green field under a blue sky. In the top right corner, the NPAS logo is displayed, consisting of a stylized blue and green wave icon next to the text "NPAS NATIONAL PATIENT ACCOUNT SERVICES". The main text in the center reads "NOW TRACKING YOUR CASH IS EASIER." Below the cow, a dark green banner contains the text "YOUR MONEY IS WAITING. TO POINT YOUR WAY TO SAVINGS VISIT" followed by the website "www.npasweb.com/hfma" and the phone number "OR CALL 1-866-882-3582".

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by the mandate, attempting to do so would require “quasi-legislative ‘line-drawing’ [that] is a ‘far more serious invasion of the legislative domain’ than courts should undertake” (*State of Florida v. U.S. Dept. of Health and Human Services*, Jan. 31, 2011 opinion).

If challenges to the Affordable Care Act eventually make their way, as expected, to the Supreme Court, and the Court finds the individual mandate provision invalid, the question of severability will come down to how central the individual mandate provision is to the remainder of the Act. If the provision cannot be severed without affecting a significant portion of the remaining Act, as Judge Vinson found, the Court could decide to strike down the Affordable Care Act in its entirety. If the provision is severable, however, as Judge Hudson found, the remainder of the Act will remain valid.

Decisions in the Federal Courts of Appeal

D.C. Circuit

Two members of a three-judge panel on the U.S. Court of Appeals for the D.C. Circuit have upheld the constitutionality of the Affordable Care Act. While the majority found the Act within Congress’s Commerce Clause powers, it also noted “that a direct requirement for most Americans to purchase any product or service seems an intrusive exercise of legislative power [and] surely explains why Congress has not used this authority before.” But, the decision concludes, “the right to be free from federal regulation is not absolute, and yields to the imperative that Congress be free to forge national solutions to national problems, no matter how local—or seemingly passive—their individual origins.”

In a dissenting opinion, Judge Brett Kavanaugh argued that the Anti-Injunction Act, which bars an individual from seeking to restrain the assessment or collection of a tax, should apply. Accordingly, the federal courts would lack jurisdiction over the case until a tax penalty for failure to adhere to the individual mandate had been assessed. Judge Kavanaugh also cautioned against side-stepping the Anti-Injunction Act too quickly to get at the underlying Commerce Clause argument, which could lead to upholding “a law unprecedented on the federal level in American history” and “usher in a significant expansion of congressional authority with no obvious principled limit.” Courts should just as cautious, Judge Kavanaugh noted, about prematurely rejecting the government’s Commerce Clause argument. “The elected Branches designed this law to help provide all Americans with access to affordable health insurance and quality health care, vital policy objectives. . . . [and] was enacted, moreover, after a high-profile and vigorous national debate. Courts must afford great respect to that legislative effort and should be wary of upending it.”

The D.C. Circuit is the fourth federal appellate court to rule on lower court decisions regarding the constitutionality of the Affordable Care Act. The decisions of the other three appellate courts are summarized below.

Fourth Circuit

In a pair of decisions, the U.S. Court of Appeals for the Fourth Circuit has upheld the Affordable Care Act. In neither case, however, did the court address the merits of claims challenging the constitutionality of the individual mandate under the Constitution’s Commerce Clause.

In the first case, *Commonwealth of Virginia v. Sebelius*, the court held that Virginia lacked standing to challenge the healthcare law, thus reversing the district court’s decision striking down the individual mandate. In the second case, *Liberty University v. Geithner*, the court held that the penalty for an individual’s failure to purchase insurance, which will be collected through the Internal Revenue Service, functions as a tax. Under the terms of the federal Anti-Injunction Act, an individual is barred from seeking to restrain the assessment or collection of a tax. Instead, the assessment must be paid; an individual can subsequently bring a refund action in the federal courts if the IRS denies a request to refund the assessment. At this time, before any penalties for the individual mandate have been assessed, the Fourth Circuit ruled that the federal courts lack power to hear a suit challenging the mandate. The Fourth Circuit is the first court to rule that the individual mandate penalty functions as a tax.

Eleventh Circuit

In a two-to-one decision, the U.S. Court of Appeals for the Eleventh Circuit upheld U.S. District Court Judge Roger Vinson’s ruling in *State of Florida v. U.S. Department of Health and Human Services* that the individual mandate exceeds Congress’s powers under the Commerce Clause. It overruled Judge Vinson; however, on the question of whether the individual mandate is severable, holding that the remainder of the Affordable Care Act is valid.

The two-member majority formulated the question before the court as “whether the federal government can issue a mandate

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that Americans purchase and maintain health insurance from a private company for the entirety of their lives.” Under this theory, the majority argued, the Commerce Clause would give “Congress the power to direct and compel an individual’s spending in order to further its overarching regulatory goals” simply because “Americans have money to spend and must inevitably make decisions on where to spend it.” This would be an unprecedented reach of congressional power under the Commerce Clause, the majority reasoned, one that stretched beyond constitutional limits. Judge Frank M. Hull, one of the two-member majority, is the first judge appointed by a Democratic president (William J. Clinton, in 1997) to rule that the mandate is unconstitutional.

Sixth Circuit

The Eleventh Circuit decision established a split with the U.S. Court of Appeals for the Sixth Circuit, which earlier this year affirmed U.S. District Court Judge George Steeh’s decision upholding the constitutionality of the Affordable Care Act in *Thomas More Law Center v. Obama*. A split between the circuits increases the likelihood that the Supreme Court will soon decide to review the constitutionality of the act.

Much attention in the Sixth Circuit case focused on Judge Jeffrey Sutton, who is the first judge appointed by a Republican president (George W. Bush, in 2003) to uphold the constitutionality of the law. Judge Sutton’s opinion does, however, leave the door open to future appeals. It notes that “the government has the better of the arguments” today, but also notes that the challenge before the court involved a “pre-enforcement facial attack on the individual mandate in all of its settings.” More typical would be an “as applied” challenge to specific parties and circumstances.

Judge Sutton joined Judge Boyce Martin, Jr., in upholding the constitutionality of the individual mandate under Congress’s Commerce Clause powers.

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Author: Don Frank, Bottom Line Systems, Inc.

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Joining now pays off for new members, and can pay off for you too! Here’s why:

- New members can save \$100 if they join now and pay their dues through May 2013.
- Current Kentucky HFMA members are eligible for the State Member-Get-A-Member incentive program. By sponsoring a new Kentucky HFMA member that joins in January or February 2012, you’ll have their name entered into a drawing for a \$250 prepaid gift card. The winner will be announced at the Spring Institute in March.

There’s more! The National HFMA Member-Get-A-Member program will continue through April 2012 and provides an additional incentive to sponsor new members. You will receive rewards for each new member you sponsor, up to \$150. On top of that, you’ll also receive an entry for a grand prize of \$3,000!

With all of these incentives to sponsor new members, now is the time to reach out to your colleagues and friends about membership. Introduce them to HFMA and the benefits of membership, all while saving them some money and making money for yourself!

Please note that in order to be eligible for either of these programs, the new member must list you as their sponsor when they sign up to join HFMA. Additional details on the national Member-Get-A-Member program can be found at www.hfma.org/mgam. If there are any questions regarding the Kentucky Member-Get-A-Member program, please contact me directly at dfrank@onlinebls.com.

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Karen Paris

Quality Administrative Assistant
Crittenden Health Systems

David Rothgerber, Jr.

Director of Early Out
Firstsource Solutions, Inc.

Mark Spurlin, II

Consultant/Accounting Analyst
Healthcare Strategy Group

John Hubbell

Chief Financial Officer
Livingston Hospital and Healthcare

Darleen Poe

VP Financial Services
SnF Management

Natalie Erlenwein

Provider Finance Manager
King’s Daughters Medical Center

Laura Werner

Catholic Health Initiatives

Healthcare Spending Growth Historically Low

An HFMA Web Extra

U.S. healthcare spending increased by 3.9 percent in 2010, a “historically low rate of growth” as the recession continued to impact healthcare providers, payers, and sponsors, according to the annual report on healthcare expenditures by the Centers for Medicare & Medicaid Services.

Total spending reached \$2.6 trillion, or \$8,402 per person, in 2010 and grew just 0.1 percent from 2009, when the lowest rate of increase in spending (3.8 percent) was recorded in the 51-year history of the annual report produced by CMS’ Office of the Actuary.

While healthcare spending remained stagnant, the growth in the overall U.S. economy as reflected by gross domestic product increased at a rate of 4.2 percent, which kept healthcare spending of GDP unchanged at 17.9 percent, according to the report.

Hospital spending increased 4.9 percent to \$814 billion, compared to a 6.4 percent increase in 2009. Growth in private health insurance spending for hospital services “slowed considerably in 2010” and accounted for 35 percent of all hospital care, CMS said.

HHS: Hospital Adverse Events Often Unreported

An HFMA Web Extra

Most in-hospital adverse events in which patients are harmed as a result of medical care are unreported by hospital staff, according to a new report by the Department of Health and Human Services.

Using incident reports from a sample of 189 hospitals where adverse events occurred, HHS found that incident reporting systems captured only 14 percent of adverse events that caused patient harm. HHS attributed the low reporting number, in part, to staff members who did not perceive the harm to the patient as a reportable event.

HHS recommended that the Centers for Medicare & Medicaid Services and the Agency for Healthcare Research and Quality work together to create a list of reportable events for hospitals and healthcare providers that would educate workers on the full range of patient harm that occurs within hospitals.



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Healthcare Hiring Continues to Grow

An HFMA Web Extra

Led by more than 10,000 new jobs created in hospitals, the healthcare industry accounted for 22,600 new jobs in December, according to figures released by the Bureau of Labor Statistics.

Employment at the nation's hospitals increased 0.20 percent from November. Nearly 90,000 hospitals jobs were created in 2011, more than double the 37,300 jobs created in 2010, the figures show.

For the year, more than 314,000 jobs were created in the healthcare sector, accounting for nearly one in five new jobs in the overall economy, figures show.

Uncompensated Care Nears \$40 Billion, AHA Report

An HFMA Web Extra

U.S. hospitals provided \$39.3 billion in uncompensated care in 2010, representing 5.8 percent of total expenses, according to data from the American Hospital Association's survey of 4,985 hospitals.

Uncompensated care - the level of care provided in which no payment was received by the patient or the insurer - increased by approximately \$200 million since 2009, the AHA said. The uncompensated care costs include bad debt, which covers services in which hospitals anticipated but did not receive payment, and charity care services, in which hospitals did not receive or expect payment due to patients' inability to pay.

IRS to Audit Based on Schedule K Disclosures

By M. Elizabeth Walker and Kendall A. Schnurpel, Hall, Render, Killian, Heath & Lyman, P.C.

Summary:

- **The IRS has made recent announcements that a round of audits for 501(c)(3) borrowers of tax-exempt debt will begin next year.**
- **The IRS acknowledges that Schedule K will be used as an audit guide. Audit yourself or we will.**
- **All health systems with outstanding tax-exempt bonds should have well-crafted written procedures for post-issuance compliance in place.**

With the effectiveness of Form 990 Schedule K (Supplemental Information on Tax Exempt Bonds) and a noticeable increase in IRS's scrutiny of tax-exempt borrowings, many in healthcare financial management will already be familiar with Schedule K reporting and post-issuance compliance regarding the use of tax-exempt bond proceeds. However, according to the IRS, familiarity and "best efforts" are not sufficient to ensure compliance. Instead, the IRS has stated that borrowers must carefully and precisely prepare their Schedule K reports, should have formal written procedures for post-issuance compliance, and should be prepared for a challenging audit if they do not.

Schedule K Review

The IRS made several announcements in October 2011 as to the IRS' intent to audit certain bond issues based on reviews of Schedule K filings. Cliff Gannett, the IRS' acting director of government entities, recently stated that the IRS will be devoting more resources to Schedule K than in past years, and that "now we'll be able to better target issuers" for audit. He also stated that this initiative will be "a plus for both the IRS and charities [because] we're better using our resources and we'll lessen the burdens on those that are continuing to monitor their post-issuance compliance and are complying with tax law requirements."

It appears that those hospitals and health systems that provide detailed and thorough responses and explanations on their Schedule K reports will both be in a better position to defend themselves in the event of an audit, and less likely to be the subject of an audit. Those hospitals and health systems that report excessive private use, no private use, or that have inconsistencies in their tax returns, without a thorough explanation of the same, may face additional scrutiny from the IRS.

Borrowers should have processes in place, involving both financial and legal personnel, to ensure that annual Schedule K reporting is accurate and thorough. In order to do so, borrowers need to be aware of the specific assets that are bond-financed, and need to ensure that all management and service contracts that involve the use of bond-financed assets are within the safe harbors of Revenue Procedure 97-13 or have been vetted by bond counsel.

Post Issuance Compliance

Technically there is no legal requirement that a borrower of tax-exempt bond proceeds have written post-issuance procedures in place, but the IRS has been sending strong signals, in its revisions to Schedule K, in its written statements, and in its closing agreement policies, that it will treat those borrowers that do have written procedures in place more favorably than those that do not.

On July 1, 2011, the IRS published final results of its 2007 post-issuance compliance check program, evaluating post-issuance compliance and record retention practices within the tax-exempt bond industry. In its final report, the IRS stressed that few respondents (16% of 501(c)(3) borrowers and 8% of governmental borrowers) had formal, written procedures and policies governing post-issuance compliance. According to the IRS, borrowers recognize the importance of post-issuance compliance and recordkeeping, but frequently fail to implement an effective compliance plan. As evidenced by this report and recent statements by IRS officials, the IRS maintains a belief that the adoption and consistent utilization of formal procedures and practices generally improves the likelihood of post-issuance compliance.

Beginning in fiscal year 2011, borrowers must also now report on their Schedule K whether or not they have written post-issuance procedures in place, both for private use and arbitrage compliance. This is in contrast to the initial 2007 Schedule K, which asked only if an organization had adopted "management practices and procedures to ensure post-issuance compliance." This change seems clearly designed to encourage all filing organizations to adopt and periodically review written post-issuance procedures.

Additionally, recent audit requests sent out by the IRS have included requests for copies of a borrower's written post-issuance compliance procedures, with additional questions as to whether or not the written procedures include procedures for a number of specific situations.

On August 11, 2011, the IRS released updated administrative procedures for the tax-exempt bond Voluntary Closing Agreement Program ("VCAP"). VCAP was established to assist organizations in resolving violations of the federal tax laws applicable to their tax-exempt bonds through the execution of "closing agreements" with the IRS. Among other reasons, VCAP may be sought when bond-financed assets have been sold or where a borrower has excessive private use. The updated VCAP procedures now permit a reduced settlement amount when an organization timely submits a VCAP request following the identification of a violation using the organization's written post-issuance compliance procedures. The update describes what constitutes "written procedures" for VCAP purposes:

"Such procedures must, at a minimum, specify the official(s) with responsibility for monitoring compliance, a description of the training provided to such responsible official(s) with regard to monitoring compliance, the frequency of compliance checks (must be at least annually), the nature of the compliance activities required to be undertaken, the procedures used to timely identify and elevate the resolution

Continues on page 10

of a violation when it occurs or is expected to occur, procedures for the retention of all records material to substantiate compliance with the applicable federal tax requirements, and an awareness of the availability of VCAP and other remedial actions to resolve violations.”

The updated VCAP also provide that, generally, reliance on bond documents, without more, will not qualify as written procedures that satisfy this paragraph. The IRS has also established a sliding scale for the amount of penalties to be assessed for VCAP filings based on how soon after the precipitating event the VCAP process is instituted, again highlighting the importance of knowing which assets are bond-financed and monitoring the use thereof.

Recommendation

All hospitals and health care systems with outstanding tax-exempt bonds need to be proactive with regard to monitoring and quantifying private use, both for Schedule K reporting, and due to increased scrutiny by the IRS on tax-exempt borrowers. Additionally, the availability of reduced sanctions when written post-issuance compliance procedures are in place, the IRS’s recent commentary, and its stated intent to conduct audits based on information in Schedule K filings suggest that every Section 501(c)(3) organization with outstanding tax-exempt debt should adopt written compliance policies and procedures governing post-issuance compliance as soon as possible. Organizations with existing written procedures should review them to verify that they conform to the minimum requirements provided in the updated VCAP procedures described above.

Raising Medicare Eligibility Age Would Cut Outlays, CBO Estimates

An HFMA Web Extra

Increasing the age in which people can begin collecting Medicare benefits would reduce federal outlays by approximately \$148 billion from 2012 through 2021, according to estimates by the Congressional Budget Office.

In the 12-page issue brief, CBO analysts estimated the impact of increasing the eligibility age by two months every year, beginning in 2014 for people born in 1949, until the eligibility age reaches 67 in 2027. CBO estimates that by 2035, Medicare’s net spending would be about 5 percent below what it would otherwise be – 4.7 percent of the nation’s gross domestic product rather than 5 percent under the current law.

CBO analysts predicted that most people affected by the increase in the Medicare eligibility age would find other forms of healthcare insurance. Out of the 5.4 million people affected by the higher eligibility age in 2021, about 5 percent would become uninsured and about half of the group would obtain insurance from their employers or former employers, according to the CBO.

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Medicaid Managed Care Moves Forward in Kentucky

Article by: Jeanene Whittaker

Eligibility errors, non-contracted status denials and pharmacy charge billing problems were not unexpected consequences of the swift implementation of Managed Medicaid in Kentucky. Many providers are still waiting on payment for services rendered to eligible Medicaid recipients 90-days post service. Providers who have not yet finalized contracts with some or all of the Payors are experiencing claim denials for no authorization in lieu of the "out-of-network" payment calculated on a percentage of the Medicaid allowable.

According to many hospitals, the Kentucky Hospital Association (KHA) has been diligent in its efforts to communicate with the Kentucky Cabinet for Health and Family Services on the Providers' behalf and continues to assist from a legislative perspective. In general, payment errors and denials appear to be common. Problems tend to repeat and corrections are still in process with the Payors. "Kentucky didn't phase-in its Medicaid MCO like other states, therefore we are experiencing a lot of noise and fallout as a result". – Russ Ranallo, Vice President of Financial Services, Owensboro Medical Health System.

Payment-Specific Issues and the actions being taken by hospitals include:

- Payor Provider Web Portal outages. Providers are encouraged to check websites for advance notification of any outages.
- System modeling issues have resulted in not only slow payment but no payments since project inception. Hospitals are working directly with Payor representatives to facilitate corrections and speed payment processing.
- Difficulty registering for the Performance Electronic Fund Transfer. Revised instructions have been posted on the WellCare website.
- 5010 conversion has been a challenge for many providers. The expectation is this issue will resolve in time.
- With respect to Lab fee schedules, if a code is not listed on the fee schedule the payment rules allow reimbursement at a cost-to-charge calculation. Instead, claims are being denied. Given the systemic nature of this issue, provider representatives are facilitating corrections.
- Certain services expected to be paid are being denied as "not covered".
- Payors are applying Medicaid rules to the managed care contract.
- OBS charges are being denied due to "Incorrect Revenue Code" when the revenue code is correct.
- OBS denied as "Inappropriately Coded" even though the coding is correct.
- Denials for services provided as "Inpatient Only" – procedures that are done on an outpatient basis.
- Payments are not being made promptly. Some hospitals are managing on a claim-by-claim basis.
- Providers are experiencing denials related to difficulty identifying the correct responsible MCO. These types of issues are being managed on a claim-by-claim basis.

Too Soon To Tell

Providers are unsure what the future holds for Managed Medicaid in the State. "The future of Region Three will be worth watching to see if Passport will increase its presence on a more broad area throughout the State." says Shelley Gast, System Director of Managed Care for Norton Healthcare. Russ Ranallo, Vice President of Financial Services for Owensboro Medical Health System believes one of the biggest unknowns is how rebasing will impact reimbursement mid-year. "Depending on the type of contract negotiated, a hospital may have agreed to accept a change that has not yet been calculated". For critical access providers, managed Medicaid will likely position them in a better position financially only if the hospitals are successful in managing cost increases.

"With Managed Medicaid now statewide for Kentucky, it is our role as healthcare leaders to follow the initiative of the Governor and take care of patients in our communities". –Shelley Gast, System Director, Managed Care, Norton Healthcare.

KY HFMA Winter Education Institute

Article by: Dan Schoenbaechler



The Winter Institute was held at Churchill Downs on January 20, 2012. The keynote speakers were Ben Schecter, Lettricea Jefferson-Webb, and Philip R. Bezeherthy from the U.S. Attorney's Office. They provided detail regarding some of the types of civil and criminal cases their office has been pursuing lately in Kentucky surrounding healthcare fraud and how they discover fraudulent activity. David Jones, Jr. from Chrysalis Ventures and former Chairman of the Board for Humana provided insight on innovating to enhance productivity and reduce costs. Morning breakout sessions were provided by Scott Bezjak and Kim Scifres from BKD, Martin Sher and Christopher Allen from AmSher Receivables Management and Steve Berger with Healthcare Insights. Bezjak and Scifres provided guidance on the much anticipated Community Health Needs Assessments requirements for the 990. Sher and Allen provided ideas and techniques to improve your culture and try to take a little of the cuss out of customer service. Berger provided metrics to use as a roadmap to hospital success.

The first afternoon breakout sessions were provided by Dick Clarke, President and CEO of HFMA, and Steve Berger of Healthcare Insights. Clarke provided insight of the healthcare reform. Berger continued his discussion of Using Metrics as a Roadmap to Hospital Success. The second afternoon breakout session was provided by Elizabeth Walker and Kendall Schnurpel of Hall Render Killian Heath & Lyman, Deb Grider of Blue & Co., LLC, and Steve Berger of Healthcare Insights. Walker and Schnurpel provided guidance on the Schedule K disclosures of the 990. Grider provided guidance for the upcoming ICD-10. Berger provided his last part of Using Metrics as a Roadmap to Hospital Success.

The final session of the day included a CFO Panel. Tim Jarm of Alliant Management Services was the moderator. Panelists included Tony Sudduth (T.J. Samson Community Hospital), Ted Miller (Floyd Memorial Hospital and Health Services), Thomas Hales (Crittenden Health Systems) and Della Deerfield (Marcum & Wallace Memorial Hospital). A variety of issues were discussed including capital issues and issues surrounding CAHs and community hospitals.

Pictured above from left to right are: Scott Reed, VP of Education, Kentucky Chapter of HFMA, Richard Clarke, President and CEO, National HFMA, and Chris Woosley, President, Kentucky Chapter HFMA.

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The Financial Diagnosis supports the mission of the Kentucky Chapter by serving as a key source for individuals involving in or interested in the financial management of healthcare.

PUBLICATION OBJECTIVE

The Financial Diagnosis is the official publication of the Kentucky Chapter HFMA and is written and edited principally to provide members with information regarding Chapter and national activities, current and useful news of both national and local significance, information about seminars and conferences and networking with colleagues, and to serve as a forum for the exchange of ideas and information.

ARTICLE SUBMISSION

The Financial Diagnosis encourages submission of material for publication. Articles should be typewritten and submitted electronically to the Editor by the deadlines listed below. The Editor reserves the right to edit, accept or reject materials whether solicited or not.

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