CCH Health Care Compliance LETTER

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Physicians prepare for quality reporting initiative

by Geraldine Szuberla, J.D., LL.M., Contributing Editor

The Physician Quality Reporting Initiative (PQRI), authorized by Title I §101 of the Tax Relief and Health Care Act of 2006, establishes a financial incentive for eligible professionals to participate in a voluntary quality reporting program. Eligible professionals who successfully report a designated set of quality measures on claims for dates of service from July 1, 2007, to December 31, 2007, may earn a bonus payment, subject to a cap, of 1.5 percent of total allowed charges for covered Medicare physician fee schedule services.

This initiative applies to the traditional Medicare fee-for-service program only and is not applicable to the Medicare Advantage Plans, including the private fee-for-service plans.

Eligible professionals. Under PQRI, to the extent covered professional services are provided to Medicare beneficiaries, those services are eligible for the bonus payment. Covered professional services are services paid based on the Medicare Physician Fee Schedule. Eligible professionals include Medicare physicians, practitioners, and therapists.

Eligible professionals need not enroll or file an intent to participate for the PQRI. They can participate by reporting the appropriate quality measure data on claims submitted to their Medicare claims processing contractor. Reporting for the 2007 PQRI begins with claims for dates of service as of July 1, 2007.

Reporting rules. To satisfy the requirements of the program and receive the bonus payment, certain reporting thresholds must be met. When no more than three quality measures are applicable to services provided by an eligible professional, each such measure must be reported in at least 80 percent of the cases in which the measure is reportable. When four or more measures are applicable to the services provided by an eligible professional, the 80 percent threshold must be met on at least three of the measures reported.

Eligible professionals should select and report measures that are applicable to their practice. To help physicians prepare for reporting under PQRI, CMS posted a list of 74 measures at http://www.cms.hhs.gov/PQRI/15_MeasuresCodes.asp#TopOfPage, which include the 66 measures from the discontinued 2006 physician voluntary reporting program. Final specifications for the 2007 PQRI measures will be published by CMS no later than July 1, 2007.

Bonus payment. Eligible professionals who participate in the 2007 PQRI program will have access to a CMS analysis of their reported data. Those who successfully report quality measure data on claims for services between July 1, 2007, and December 31, 2007, will be eligible for a single consolidated incentive payment in mid-2008. ■

CMS, //www.cms.hhs.gov/PQRI/, Feb. 23, 2007.

Examining definitions is crucial to Stark law compliance

by Catherine Hubbard, M.A., Contributing Editor

When dealing with a possible Stark law violation, legal counsel will need to pay extra attention to definitions contained in the law and preambles, according to experts at a recent audioconference sponsored by the American Bar Association. "Definitions are particularly important in the Stark law," said Linda Baumann, partner with Reed Smith, Washington, D.C, and Arent Fox, founding partner of Arent Fox LLP, Washinton, D.C.

"The terms are defined in a unique way," Baumann said, adding that "[t]his is a very complex law." As an example, she said the definition of "physician" for purposes of the Stark law includes only medical doctors, osteopathic doctors, dentists, podiatrists, optometrists, or chiropractors – not nurses.

Immediate family. The definition of "immediate family members" goes considerably beyond what most people would consider the immediate family, Baumann said.

An immediate family member under Stark is a husband or wife, parent, child, sibling, stepparent, stepchild, stepbrother/stepsister, father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, sister-in-law, grandparent or grandchild, or spouse of a grandparent or grandchild. "There are a lot of grey areas," she noted.

Kevin Barry, with Reed Smith, Washington, D.C., added that the definition of "immediate family members" is "extremely broad" and "can be unruly on a practical level." For instance, if a physician's grandmother marries, that step-grandfather would be an immediately family member who could raise some Stark issues if he takes a job as a receptionist at a hospital, he said.

Designated health service. Lawyers also should look at the definition of "designated health services" and the exception for composite rates, the attorneys said.

Designated health services (DHS) include among other things:

- clinical laboratory services,
- physical and occupational therapy,
- radiology and certain other imaging services,
- radiation therapy,
- durable medical equipment and supplies,
- parenteral and enteral nutrients,
- prosthetic devices,
- home health services,
- outpatient prescription drugs, and
- inpatient and outpatient hospital services.

DHS does not include services that are paid by Medicare as a composite rate, such as services in the ambulatory surgery center composite rate or skilled nursing facility Part A services, unless the DHS is itself payable as a composite rate, Baumann noted. DHS also does not include invasive radiology and some diagnostic radiology procedures. "Certain composite rates will keep you out of Stark," she said.

Referral. The definition of "referral" contains certain exceptions of which lawyers should be mindful. A referral means a physician's order certifying or recertifying the medical necessity of any DHS for which payment may be made under Medicare Part B, Baumann explained. This includes a request for a consultation with another physician and any test or procedure ordered by or to be performed by that other physician, she added.

A referral also means a request by a physician that includes the provision of DHS and establishment of a plan of care that includes the provision of DHS, or certifying the need for DHS, Baumann said.

A referral, however, does not include services personally performed by the referring physician, she clarified. "You're going to be out of Stark law problems if the physician is personally performing that service," Baumann noted.

Fiancial relationship. Another area of caution of is whether a financial relationship is direct or indirect, Baumann said. A financial relationship is defined as a direct or indirect ownership or investment interest by a physician (or immediate family member) in an entity that furnishes DHS, or a direct or indirect compensation relationship with such entity, according to a handout provided by the speakers.

In a direct relationship, there is no person or entity interposed between the DHS entity and referring physician. In an indirect relationship, at least one person or entity is interposed between the DHS entity and the referring physician. Direct or indirect "can make a big difference," Baumann emphasized. ■

CCH Washington Bureau, Feb. 8, 2007.

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Tax–Jeff Carlson, Steve Cooper

Designer
Kristin Baer

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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Inadequate oversight, fraud increase cost of drug programs

by Valerie Witmer, J.D., and Stacey Fahrner, J.D., M.P.H, Contributing Editors

The government is overspending on the federal drug programs as a result of inadequate agency oversight and fraudulent activities, according to recent testimony before the House Oversight and Government Reform Committee by the Government Accountability Office (GAO) and Lewis Morris, Chief Counsel to the Inspector General.

The testimony may impact the administration of the federal drug programs given the increasing cost of prescription drugs. Medicaid expenditures for prescription drugs in 2005 were estimated at $41 billion, a more than four-fold increase over the $8.9 billion spent in 1994. Likewise, Medicare expenditures for prescription drugs increased from approximately $1.4 billion in 1994 to $10 billion in 2005.

Inadequate oversight. The GAO limited its testimony to the lack of proper oversight of discount drug pricing in the Medicaid drug rebate program, the 340B discount drug program, and Medicare Part D.

With respect to the Medicaid drug rebate program, the GAO reported inadequacies in CMS oversight of the prices reported by manufacturers, which ultimately determine the rebates owed to states. The lack of oversight included inadequate guidance to manufacturers for calculating these prices.

Inadequacies in the oversight of the 340B drug pricing program by the Health Resources and Services Administration (HRSA) included a lack of transparency in the maximum prices (called 340B prices) charged to eligible entities. According to the GAO, HRSA did not routinely compare the prices actually paid by eligible entities. Consequently, many eligible entities overpaid for 340B drugs. Because pricing information is not disclosed to eligible entities, they are not able to determine whether the amount they pay is at or below the maximum price.

Certain features of the Medicare Part D program make it vulnerable to similar oversight challenges. For example, Part D relies on private organizations to report price concessions from manufacturers, similar to the Medicaid rebate program.

The GAO recommended that the House Committee consider previous occurrences of oversight inadequacies, inaccurate prices, lack of transparency, and potential for abuse as it develops its oversight agenda.

Fraud. Morris testified that the government has paid too much for prescription drugs because of fraudulent and abusive schemes targeting federal health care programs. His testimony focused on the enforcement work that the Office of Inspector General (OIG) has undertaken to combat fraud in the pharmaceutical industry.

According to Morris, there are three primary categories in which fraud has been identified:

- fraud in prescription drug pricing, including average wholesale price manipulation and fraud in the Medicaid drug rebate program;
- fraud in prescription drug marketing, including illegal kickbacks to prescribing physicians, use of kickbacks to promote drugs for unapproved uses, and off-label promotion of prescription drugs; and
- fraud in the delivery and dispensing of prescription drugs by pharmacies and pharmacy benefit managers, including billing the federal health care programs for prescription drugs that were not provided to beneficiaries, switching the drug prescribed to the patient to exploit reimbursement rules, and short-filling prescriptions.

OIG intends to enhance existing fraud prevention and detection efforts by increasingly using its administrative authorities to sanction individuals engaged in fraudulent and abusive practices and using its authority to impose program exclusion and significant monetary penalties to target kickback recipients. OIG also has issued a compliance program guidance that provides detailed information for drug manufacturers on establishing and operating an effective internal compliance program and identifying fraud and abuse risk areas. ■

GAO Report, GAO-07-481T, Feb. 9, 2007.
OIG Testimony, Feb. 9, 2007, Health Care Compliance Reporter, ¶530,510.

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On The Front Lines

Experts advise on community benefit, Form 990 challenges

by Larry Perlman, C.P.A., J.D., LL.M, Contributing Editor

A new report on the recent Internal Revenue Service (IRS) community benefit questionnaire has been released and the report, along with Form 990, e-filing, nonprofit alternative investments, and joint ventures, were among the hot topics addressed at the recent Ernst & Young's 16th Annual Health Sciences Tax Conference in Orlando, Fla. CCH's tax-exempt organizations editor and Health Care Compliance Newsletter contributor, Larry Perlman, recorded the highlights of the conference and reports in this article expert advice on documenting community benefit.

Ernst & Young (E&Y) prepared a report for the American Hospital Association (AHA) based on the Internal Revenue Service (IRS) community benefit questionnaire. IRS Form 13790, *Compliance Check Questionnaire Tax-Exempt Hospitals,* was sent to 544 hospitals on a random basis asking about compliance with recordkeeping and information requirements, information on the hospital's community benefit, and compensation practices.

The E&Y report was based on submissions by 132 of the hospitals that responded to the IRS survey and voluntarily submitted their responses to E&Y at the request of the AHA. It did not consider the compensation piece of the questionnaire.

The report found that:

- 100 percent of the hospitals provided services to all members of the community regardless of the patient's ability to pay;
- all participants had adopted a written charity care policy;
- uncompensated care was provided to 12 percent, on average, of a hospital's patients during the year; and
- before additional information on nonprofit hospitals is required on Form 990 (*Return of Organizations Exempt From Income Tax*), definitions need to be clarified to promote uniform answers. For example, the report found that the definition or interpretation of the word "denial of services" is unclear.

Maureen Mudron, AHA Washington Counsel, emphasized that for "hospitals, it is important to tell your community benefit story on the questionnaire and in the Form 990." Mudron said that the most recent AHA board statement included calls for standardized public reporting of community benefit as an attachment to Form 990.

Increased scrutiny

Howard Levenson, Ernst & Young, Washington, D.C., noted that many states are looking at community benefit/charity care as a basis for denying exemption from state taxes. Levenson warned, "[I]f it hasn't happened yet, [community benefit scrutiny] is coming to a state near you." "At a minimum there is likely to be increased reporting on the Form 990," he said. One goal of the report was to make sure that if some version of the questionnaire was incorporated into Form 990, certain terms were clarified.

"I've been concerned that the tendency of legislators is to confuse the problem of the uninsured with charity care," Levenson commented. "Nobody is denying that the problem with the uninsured is a significant problem in this country, but not all uninsured are initially eligible for charity care. It's a completely different problem that should not be resolved solely on the backs of the tax-exempt hospitals."

Lucille White, Ernst & Young, Chicago, Illinois, listed best practices that hospitals should consider in light of intensified scrutiny:

- Compare the estimated value of the organization's federal and state tax-exempt status to the value of the organization's charity care and other community benefits. It is "extremely critical" that you are aware of these values, which will help in case of any challenges.
- Be responsive and transparent in correspondence with the state and local taxing authorities. "To the extent you are proactive and do your homework, you won't be caught off guard."
- Review charity care policies, and monitor compliance and collection practices. "It is not good enough to just have guidelines; make sure you monitor compliance with them."
- Consider value-based appeals of assessments as a protective measure to preserve a tax-exempt hospital's appeals rights and to control costs. This is especially important if your property tax exemption is under challenge. "Many of our tax-exempts don't have a county assessment; one may not have been made." Advisors should consider the statute of limitations when considering whether to challenge assessments.

She added that property tax challenges generally require administrative remedies to be exhausted before litigation can be pursued, and litigation can be protracted. In addition, community benefit information on a hospital's Web site should be consistent with the hospital's Form 990, advised Katherine Kurtzman, Ernst & Young, Chicago, Illinois.

Compensation

Compensation has been on the IRS' radar for quite some time. While this is nothing new, recently they have been getting much more active in the area, Linda Mason, Ernst & Young, Miami, Florida, said.

"They are looking for transparency, how decisions are being made, and the relationships among the people involved. Basically, what they are looking for is making sure that organization assets are used for exempt purposes." Mason noted that gift certificates, forgiveness of debt, and spousal travel are often missed when determining compensation and reporting on Form 990.

She described some leading practices in approving and documenting compensation:

- In approving compensation, consider all items of compensation, including items such as cell phones and automobiles.
- Make sure job descriptions agree with the title. "Just because someone has a title 'director' does not mean they are performing the functions of a director."
- The comparables should make sense. Size and location matter. "Don't compare compensation at a small rural hospital to a large urban hospital."
- Lack of documentation gets people in trouble. The organization should have sufficient detail when documenting board approval. Approval needs to be recorded in either the board or committee minutes. "You need to have sufficient detail, which should include the categories and amounts agreed to."
- Documentation should be adequate and contemporaneous. "It is not enough to say 'compensation was discussed.' This can't be done when the IRS comes calling."
- Reasonable compensation not properly approved could lead to an automatic excess benefit transaction, she warned.
- Officers should recuse themselves from the discussions regarding compensation.
- Use independent compensation consultants. This helps show the due diligence of board.
- Compare the year-end plan against the actual amount paid. Common reasons amounts paid do not agree with the plan include car allowance issues, spousal travel that was not considered, gifts, the personal portion of cell phones, and bonus adjustments.

The most common reason for errors in Form 990 disclosure, according to Mason, is that the person completing the return is not aware of the benefit; this is especially true of executive plans. A company should have a multi-level review and gathering of compensation information.

"... many states are looking at community benefit/charity care as a basis for denying exemption from state taxes."

Lobbying activities

Kurtzman reminded practitioners that charities may lobby, but political activities and contributions are specifically prohibited. She said that the IRS finds political contributions by going to a political organization's Web site or from whistleblowers.

Joyce Hellums, Ernst & Young, Austin, Texas, noted that according to an IRS official she talked to, "100 percent of his audits in the area of potential political activities and excess lobbying activities by exempt organizations last year were initiated from referrals."

As an illustration of what the IRS didn't like, Hellums discussed the quid pro quo concerns the IRS has, including one example in which nonprofit hospital executives participated in a car wash. Individuals got their cars washed in return for a donation to a political action committee.

"It really is the small things that [trip] you up," Kurtzman said.

"If you do discover political activity, file Form 4720 to report the excise tax due, and/or the Form 1120-POL. Disclose it, get the money back, and make sure it doesn't happen again," Kurtzman advised. "If you do those things, the IRS will go easier on you if you take those [remedial] actions. Don't just push it under the rug; deal with the situation and move forward."

E-filing

Mandatory electronic filing is now required for many exempt organizations and private foundations. "The IRS wants everything e-filed," observed Mason. There are certain fields on Form 990 that will accept only numeric entries, such as officers' "hours per week" devoted to the position. She said that nonformatted text fields should not be used in areas that require alpha numeric characters. For example, entering "40+" in the field for hours worked would create a rejection.

Other common rejection issues Mason has seen include incomplete addresses and the use of symbols. The zip code must be five, and not nine, digits. Also, spell out "section" instead of using the section symbol.

"Let's start early to get these issues resolved," she encouraged the nonprofit organizations and their tax preparers.

Mason said that 40 percent of rejections are because of an incorrect name or employee identification number. She suggested filing an early electronic extension as a good check, even if an organization is filing on paper.

She also suggests filing earlier to allow time to clear rejections. The IRS allows 20 calendar days to clear rejections.

There have been many issues with software providers. The IRS wants to make clear that although they have approved a software provider for exempt organization filings, that does

not mean that the provider will meet all of the requirements. Be very careful, ask questions, and make sure your needs will be met by that software provider, she said. "You may get what you pay for," cautioned Hellums.

In addition, no negative numbers are allowed on the balance sheet or other fields, including negative income flowing through from a partnership or K-1, said Jennifer Rhoderick, Ernst & Young, Indianapolis, Indiana. "It is not a software issue, it is what the IRS is accepting." One solution is to add or net the negative income to the "other income" line.

Alternative investments

An increasing share of nonprofit organizations' investment portfolios are being allocated to alternative investments, such as hedge funds and private equity funds. Some types of alternative investments are very popular with investment fund managers.

There are two reasons organizations are turning to alternative investments, Robert Vuillemot, Ernst & Young, Pittsburgh, Pennsylvania, said. First, there is a perception among treasury directors that risk-adjusted rates of return have been very positive compared to the bonds and the equities markets. The second reason, he said, is diversification. In many cases "there is a very low correlation [with respect to] the returns on alternative investments and returns on more traditional investments."

"It really is the small things that [trip] you up."

He cautioned, however, that tax-exempt bond covenants may restrict these types of investments. For instance, a covenant may require an organization to have a certain number of days of cash on hand.

Even if there is no tax issue related to the investments, there may be a valuation issue. Tricia Bires, Director of Treasury, University Hospitals, Cleveland, Ohio, said that there is a "two-inch binder we go through for due diligence."

"Most of the issues we've seen are valuation," Bires stated. "Our auditors have been very stringent. They requested strict documentation on valuation."

Unrelated business income (UBI) from alternative investments is "somewhat of an emerging issue," according to Vuillemot. If an organization or pension trust's UBI is greater than $1,000, a Form 990-T must be filed. There are also a number of reporting requirements in which hedge funds invest in foreign activities or create state tax nexus in states that tax UBI. For example, if an oil and gas fund invests in many states there may be filing responsibilities in those states. Failure-to-file penalties can be significant, and the statute of limitations does not begin to run if returns are not filed.

Vuillemot said that one planning strategy is the use of a blocker corporation. An exempt organization may be able to avoid unrelated business income from a partnership by establishing a blocker corporation, generally in a foreign tax-advantaged jurisdiction, to hold the partnership interest. Dividends from the blocker corporation generally will not be taxable as UBI. The IRS blessed this strategy in a series of private letter rulings.

Another significant issue that may arise when investing in these alternatives, he said, concerns reportable transactions. If a nonprofit invests in a hedge fund, and the fund engages in a reportable transaction, participation in the reportable transaction is attributed back to the nonprofit.

If the alternative investment is involved in a reportable transaction, directly or indirectly, the exempt organization must report the transaction to the IRS on Form 8886, *Reportable Transaction Disclosure Statement.* Furthermore, a number of states have now enacted similar reporting requirements.

Kim Scifres, Ernst & Young, Louisville, Kentucky, suggested that "you may want to consider adopting a policy that requires your investment committee to identify potential UBI and reportable transactions prior to making any alternative investment decisions."

Joint ventures

At the conference, Levenson also discussed recent rulings on ancillary joint ventures, including Rev. Rul. 2004-51 (activities of the venture were substantially related to the exempt purpose of the exempt organization) and LTR 200605013 (regarding clinical lab testing services). He said that there are no court cases in the area and it is unlikely there will be any because the dollars involved generally are too small to litigate.

In response to whether it is necessary to provide charity care in ancillary joint ventures, Levenson stated that to the extent charity care is provided, it will enhance the nonprofit's position. The IRS will look at the activity at the joint venture level as if it were performed by the exempt organization. If the venture simply refers charity care patients back to the hospital that would be the least favorable fact pattern from an IRS perspective.

It would be "a little better," he added, if the venture had a charity care policy but provided little or no charity care because charity care patients generally do not present themselves for the medical service offered.

Another option is for the joint venture to have a minimum charity care dollar requirement, with any shortfall paid in cash to the exempt partner. "I like this idea if you can get it into the agreement. The beauty of a provision like this is that it removes disincentives for the physician partners not to treat charity care patients. They know if they don't treat charity care patients they will have to fork over money."

Levenson said that he looks at whether the activity is an exempt function for the hospital. "The more charitable you can make it, the better. To the extent the joint venture provides charity care, it is going to enhance your position with the IRS. That doesn't mean a position can't be taken on a tax return that it is exempt income because it is an activity (i.e., provision of health care services) that the hospital can provide without having UBI." ■

Larry Perlman, C.P.A., J.D., LL.M., is a Writer/Analyst with CCH, a Wolters Kluwer business. He writes for federal tax products, including Tax Day, the Exempt Organizations Reporter, and the Tax-Exempt Advisor newsletter.

IRS issues governance guidelines for exempt organizations

by Valerie L. Witmer, J.D., Contributing Editor

The Internal Revenue Service (IRS) has released a set of suggested governance guidelines intended to help tax-exempt organizations maintain regulatory compliance and public support. The release of these guidelines indicates that the IRS plans to continue focusing on the governance of tax-exempt organizations.

Good governance practices. The guidelines specifically suggested the following practices to promote effective governance and ensure satisfaction of exempt purposes:

- A mission statement explaining why the charity exists, what it seeks to accomplish, and what activities it will undertake to achieve its goals.
- A code of ethics to communicate a strong culture of legal compliance and ethical integrity, as well as whistleblower policies and procedures for reporting financial impropriety and misuse of the charity's resources.
- Policies and procedures to help directors meet their duty to act in good faith and in the charity's best interests.
- A conflict of interest policy that ensures that directors act consistently with their duty of loyalty to the organization, prevents any self-dealing, and requires annual reporting of any potential conflicts of interest.
- A policy to ensure transparency in the organization's operations and finances by making sure that the charity's Form 990, annual reports, and financial statements are complete, accurate, and publicly available.
- Policies to ensure that fundraising solicitations meet federal and state requirements, solicitation materials are accurate and truthful, and fundraising costs are reasonable.
- Financial audits to ensure that the charity operates in accorance with an annual budget approved by the board of directors.
- Policies discouraging compensation of directors and ensuring that compensation to officers and staff is reasonable.
- Written standards for document integrity, retention, and destruction, including guidelines for handling electronic files.

Board member oversight. In introducing these governance practices, Marvin R. Friedlander, chief of the IRS' Exempt Organizations Technical Branch, stressed that exempt organization board members must be informed in critical areas involving accounting, finance, compensation, and ethics. Board member must be active in overseeing the charitable organization's operations and finances, and intolerant of secrecy or neglect that might lead to waste of charitable assets. With regard to the proper size of a board, Friedlander said the IRS has adopted the "Goldilocks approach: not too big, not too small." He cautioned that a very small board might not represent any public interest, and a very large board might not be attentive to oversight.

Although satisfaction of the guidelines is not a requirement for tax exemption, the IRS believes that "an organization that adopts some or all of these practices is more likely to be successful in pursuing its exempt purposes and earning public support." Friedlander added, "In the end, an organization's good governance practices should keep regulators happy and help tell a good story to the public." ■

AHA Press Release, Feb. 5, 2007.

Alliance for Advancing Nonprofit Health Care Press Release, Feb. 5, 2007.

IRS Release, Feb. 2, 2007.

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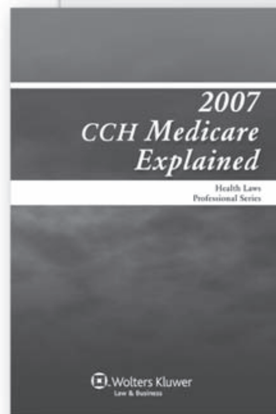

- Medicare Part A: Hospital Insurance Benefits for the Aged and Disabled
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Trends

Genetic nondiscrimination bill advances

by John Scorza, Contributing Editor

A bill to protect personal genetic information from misuse by employers and insurance companies was approved by the House Education and Labor Committee on February 14, 2007. The Senate Health, Education, Labor and Pensions Committee recently passed companion legislation (S. 358), and President Bush has indicated his support for a prohibition against genetic discrimination.

Like the Senate bill, the House proposal, the Genetic Information Nondiscrimination Act (H.R. 493), would prohibit employers, employment agencies, and labor organizations from using genetic information when making hiring, firing, job placement, or promotion decisions. It would make it illegal for group health plans and health insurers to deny coverage to healthy individuals or charge them higher premiums based on a genetic predisposition to a disease.

The bill's supporters say it would encourage Americans to take advantage of genetic testing without fear of discrimination. Rep. Louise M. Slaughter (D-N.Y.), the bill's sponsor, said her legislation would "help our country to be a leader in a field of scientific research that holds as much promise as any other in history."

Recent cases, Slaughter said, highlight the need for the protections contained in her legislation. In 1998, Lawrence Livermore Laboratories in California was found to have performed tests for syphilis, pregnancy, and sickle cell anemia on employees without their knowledge or consent, Slaughter said. In 2000, the Burlington Northern Santa Fe Railroad came under considerable criticism for performing genetic tests on employees without their knowledge.

Slaughter's bipartisan bill enjoys considerable support in the House, with more than 200 co-sponsors. The Senate passed similar legislation in the 108th and 109th Congress, but those bills failed to become law.

According to the Education and Labor Committee, 41 states have passed laws to prohibit discrimination in the individual health insurance market, and 34 states ban genetic discrimination in the workplace. ■

CCH Washington Bureau, Feb. 15, 2007.

In the News

CMS proposed changes to ABN

CMS is proposing to revise the Advanced Beneficiary Notice (ABN), the form used to inform beneficiaries of potential financial liability, by combining the two current versions, general and lab-test specific, into one version to meet both needs. Other proposed changes include: adding more user friendly language; adding the 1–800–MEDICARE number on the notice; adding information about the beneficiary's right to demand Medicare be billed; increasing the selection options from 2 to 3 to allow beneficiaries the right to pay out of pocket when they desire; allowing a place for other insurance information to be recorded; and describing the significance of the signature.

Notice, 72 FR 8167, Feb. 23, 2007.

CCHIT seeks comments on inpatient EHRs

The Certification Commission for Healthcare Information Technology (CCHIT) products, is accepting comments on its Second Draft Criteria and Test Strategy for certification of Inpatient Electronic Health Records (EHRs) for 2007. CCHIT was awarded a three-year contract by HHS to develop and evaluate certification criteria and create an inspection process for health information technology. In the second draft for inpatient health records, there were extensive changes to the interoperability criteria. Public comments must be submitted on-line before March 16, 2007.

CCHIT Release, Feb. 13, 2007.

Health care spending expected to double in 10 years

Spending on health care is expected to double by 2016, according to CMS analysts. During a press briefing, analysts said out-of-pocket expenses are expected to increase from a recent level of $850 per year to just over $1,400 by 2016. Medicare Part D will increase Medicare spending, but will slow Medicaid spending, according to the analysts. Prior to 2006, about 6 million dual eligible beneficiaries received drug benefits through Medicaid, an analyst said, adding that the dual eligibles' shift from Medicaid to Medicare drug coverage contributed to a 22.1 percent Medicare growth rate in 2006 and to an "exceptionally low" growth rate for Medicaid in 2006. "We expect national health expenditures as a percent of the gross domestic product (GDP) to climb from 16 percent now to 19.6 percent by 2016," said one analyst.

CCH Washington Bureau, Feb. 20, 2007.

Congress reacts to Medicare/Medicaid cuts in Bush budget

President Bush's $2.9 trillion budget proposal for fiscal year 2008 would cut roughly $100 billion in Medicare and Medicaid spending over the next five years as part of a plan to balance the budget by 2012. The proposal would save $76 billion in legislative and administrative changes to the Medicare program over five years and slow the program's growth rate from 6.5 percent to 5.6 percent. It also proposes legislative and administrative changes estimated to save $25.7 billion from the Medicaid program over the next five years, according to HHS Secretary Michael Leavitt. The budget cuts funding to Medicare and Medicaid "while failing to reinvest those funds to help cover any of the 47 million uninsured Americans and also not providing State Children's Health Insurance Program (SCHIP) sufficient funds to reduce the number of uninsured children," said House Speaker Nancy Pelosi (D-Calif.). In contrast, Senate Finance Committee ranking member Charles Grassley (R-Iowa) credited Bush with developing concrete proposals that are politically unpopular.

CCH Washington Bureau, Feb. 6, 2007.