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Growth in health spending outpaces national economy

National health expenditures are expected to grow at a lower percentage in 2009 than in 2008, but health care will continue to make up an increasingly large portion of the nation's gross domestic product (GDP) and outpace growth in the overall economy, according to a report by CMS' Office of the Actuary.

In 2008, growth in national health expenditures is expected to be 6.1 percent, with health spending increasing from $2.2 trillion in 2007 to $2.4 trillion. The health share of GDP is expected to rise from 16.2 percent in 2007 to 16.6 percent in 2008. In 2009, growth in health expenditures is expected to slow to 5.5 percent, while the GDP is projected to decrease 0.2 percent. The health share of GDP is expected to reach 17.6 percent in 2009.

Economic downturn. Health care expenditures will be impacted by the ongoing national recession, with hospital spending growth dropping from 7.3 percent in 2007 to a projected 5.7 percent in 2009. Hospital price growth also is expected to decelerate to the lowest rates since 2000.

Prescription drug spending growth is expected to fall from 4.9 percent in 2007 to 3.5 percent in 2008, as consumers fill fewer prescriptions or switch to lower-cost generic drugs. Private health spending growth, which includes growth in private health insurance spending and out of pocket payments, is projected to fall from 5.8 percent in 2007 to 5.3 percent in 2008. In 2009, it is expected to drop to 3.9 percent, a 15-year low.

Expected recovery. The report projects that the economy will begin to recover in 2011, with national health expenditures rising to 7.2 percent by 2018. Between 2008 and 2018, average annual health spending growth is projected to be 6.2 percent, outpacing the 4.1 percent expected annual growth in the overall economy during that period. By 2018, national health spending is expected to reach $4.4 trillion and comprise more than one-fifth of the GDP.

Private health spending growth is expected to rebound from 4.2 percent in 2010 to 6.1 percent in 2018, while public spending growth is projected to accelerate from 5 percent in 2010 to 8.2 percent in 2018. Large numbers of baby boomers will become eligible for Medicare during that period and Medicare spending growth is expected to rise to 8.6 percent in 2018.

The health care spending projection data can be found on the CMS Web site at http://www.cms.hhs.gov/NationalHealthExpendData/03_NationalHealthAccountsProjected.asp. ■

CMS News Release, Feb. 24, 2009

Wolters Kluwer Law & Business

Agency reps discuss PSO program implementation

The Agency for Healthcare Research and Quality (AHRQ) and the Office of Civil Rights (OCR) have begun in earnest the implementation of the Patient Safety and Quality Improvement Act (PSA) (PubLNo 109-41). William B Munier, MD, MBA and Larry Patton, of AHRQ and Verne Rinker, JD, MPH of the OCR addressed the purpose of the Act and the roles of the agencies they represent at an American Bar Association audio conference on January 22, 2009.

The PSA was enacted to encourage health care providers to examine their practices and develop quality improvements without fear that their work would be used against them in medical malpractice litigation, Munier explained. Toward that end, the Act protects "patient safety work product" (PSWP) from disclosure and prohibits its use in any litigation or disciplinary proceedings involving a provider or practitioner. Participation in the program is voluntary, Munier stressed. The goal of the Act is to develop uniform protection across the country, he added.

AHRQ activities. The AHRQ statutory responsibilities include: (1) assessing patient safety organizations' (PSOs) compliance with the requirements; (2) developing common formats and definitions to enable PSOs to compare similar events among similar providers; and (3) providing technical assistance to PSOs for use of common formats and de-identification of patient safety work product, Munier said.

A key aspect of the PSA is the establishment of a network of patient safety databases (NPSD) aggregating data without patient-identifying information According to Munier, the data will be aggregated at several levels by individual providers, PSOs, and networks. The NPSD will develop benchmarks and baselines for measurement, identify safety issues and best practices and publish its findings.

Approval of PSOs. The AHRQ approves entities to act as PSOs that will contract with providers to collect and analyze patient safety data, Patton said. Health insurers and their components; entities that regulate, license, or accredit providers; and agents of regulatory entities may not be approved as PSOs. Components of licensing, regulatory or accreditation organizations are eligible for approval subject to heightened restrictions.

Once a PSO is approved, compliance will be assessed by spot checks and the PSO will be subject to penalties for false statements, Patton noted. He stressed, however, that the AHRQ would resolve deficiencies in PSO compliance with requirements with technical assistance in a nonadversarial manner. According to Patton, the rules assume that providers are in the best position to assess the value of individual PSOs.

A PSO may be removed from the AHRQ list if its listing period expired after three years unless the PSO has requested and the Secretary approved continued listing; the PSO voluntarily relinquishes its status; or the PSO status has been revoked for cause, such as it is out of compliance, Patton noted.

Common formats. PSOs are required to collect information that allows comparison of similar events among similar providers using common formats developed by AHRQ, Munier said. The common formats standardize the patient safety event data collected by using common language and definitions and common style and format for data elements. In addition, common formats provide for shared learning and trend and pattern comparison at local, regional, and national levels, he added.

Disclosure of information. PSOs must fully disclose their relationships with contracting providers, according to Patton. In addition, PSOs are required to explain how they would perform patient safety activities in the context of their existing relationships.

PSWP is privileged and cannot be subpoenaed, be the subject of discovery, or be admitted as evidence in a civil, criminal, or administrative proceeding subject to certain exceptions, Rinker explained. A PSO must notify a provider if PSWP has been disclosed without authorization or there has been a breach of security.

Enforcement. The OCR, which also enforces the HIPAA privacy rule, enforces most of the PSOs' confidentiality obligations including disclosure exceptions, investigations of alleged impermissible disclosures, and imposition of civil money penalties. According to Rinker, the enforcement system will be "complaint-driven" and based on the HIPAA system, though OCR may conduct compliance reviews. ■

CCH Chicago Bureau, Jan. 29, 2009

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GAO predicts transition to national health IT system will be challenging

The transition to a system of health information technology (IT) has the potential to improve the quality and efficiency of health care delivery but will require an important national discussion to establish standards and address existing public concerns about personal privacy, according to a Government Accountability Office (GAO) report entitled "Health Information Technology: Federal Agencies' Experiences Demonstrate Challenges to Successful Implementation."

The GAO explained that achieving widespread adoption and implementation of health IT will hinge on receiving input from all important stakeholders, including health care consumers, public and private health care providers, patient advocates, insurance companies, government entities, nonprofit organizations and commercial technology providers. "Developing, coordinating and agreeing on standards are crucial for allowing health IT systems to work together and to provide the right people access to the information they need," the GAO noted.

Benefits. Government officials have long touted health IT's potential to reduce the cost of health care by making the collection, storage, and retrieval of medical data more efficient. In 2003, a 1,900-bed teaching hospital reported that it realized about $8.6 million in annual savings by replacing outpatient paper medical charts with electronic medical records. A national, interoperable system of electronic health care records, as well as other technologies such as bar coding drug and biological product labels, also would help cut down on errors, the GAO found.

Making the transition to a national health IT system, however, will be a complicated process. "Achieving this transition and the potential efficiencies and quality improvements promised by widespread adoption of health IT will require consideration of many serious issues, including the need for a foundation of clearly defined health IT standards that are agreed upon by all important stakeholders, comprehensive planning grounded in results-oriented milestones and measures, and an approach to privacy protection that encourages acceptance and adoption of electronic health records," according to the GAO.

Standards. The greatest challenge to developing a national health IT system is establishing a level of interoperability. That is, ensuring that two or more systems can exchange information and use the information that has been exchanged thus allowing patients' medical data to move with them from provider to provider. Allowing health care providers and hospitals to make use of information they receive electronically requires consistent, agreed-upon standards.

"In the health IT field, standards may govern areas ranging from technical issues, such as file types and interchange systems, to content issues, such as medical terminology," the GAO reported. A number of federal-level standards initiatives have begun that will be essential to extending the use of health IT and achieving its potential benefits, the GAO said.

Measures and milestones. Because of the wide variety of stakeholders involved in the transition to a national health IT system, planning and coordinating the many activities under way will be critical, according to the GAO. Milestones and performance measures must be established to that various ongoing activities can be monitored and assessed and corrective action can be taken if needed.

"Across our health IT work at HHS and elsewhere, we have seen other instances in which planning activities have not been sufficiently comprehensive," the GAO noted, citing problems the Department of Defense and the Veterans Administration have experienced in exchanging electronic health information.

Privacy concerns. Another key challenge in the implementation of a national health IT system is the risk that a breach in security could expose the personal health information of a large number of patients. "As the use of electronic health information exchange increases, so does the need to protect personal health information from inappropriate disclosure," the GAO found. "Addressing and mitigating this risk is essential to encourage public acceptance of the increased use of health IT and medical records."

The text of the GAO's report is available at: http://www.gao.gov/new.items/d09312t.pdf. ■

CCH Chicago Bureau, Jan. 28, 2009

States Seek to Measure Charity

by Douglas A. Pessefall, JD, and Joseph A. Pickart, JD

These are difficult economic times for everyone as states and municipalities struggle to increase spending and balance budgets without raising taxes. In the meantime, there continues to be tremendous growth in the assets and revenues of tax exempt organizations. That growth, especially when combined with increasing numbers of organizations that exchange services for fees (not unlike their for-profit counterparts), has led to raised eyebrows and calls for better measures of the community benefits provided by such organizations to justify continued exemption from income, property and sales taxes.

This article describes the scope of our nation's growing charitable sector, offers a sampling of recent state court decisions involving charitable property tax exemptions, briefly discusses efforts by the Internal Revenue Service (IRS) to develop measures of community benefits and good corporate governance, and offers recommendations for charitable organizations (particularly those in the health care industry) and the practitioners who represent them.

A Snapshot of the U.S. Charitable Sector

In 1995, approximately 180,000 charitable organizations[1] filed Form 990 annual information returns with the IRS, reporting assets of approximately $1.3 trillion and revenue of $788 billion.[2] Just 10 years later, in 2004, the number of charitable organizations filing Form 990 had grown by more 50 percent to approximately 275,000 reporting assets of $2.1 trillion and annual revenue of $1.2 trillion.[3] In all, the IRS formally recognized nearly 920,000 active charitable organizations in 2004, including approximately 36,000 health organizations holding $800 billion in assets and generating annual revenue of approximately $655 billion.[4]

The IRS has estimated that growth in the charitable sector outpaced the growth in the U.S. gross domestic product 300 percent to 74 percent in a similar period. None of these figures, however, tell the whole story because the figures generally exclude the assets and revenue of private foundations, religious organizations, and the numerous charitable organizations with annual revenues of less than $25,000.

With the growth in the sheer numbers of charitable organizations and the magnitude of their assets and revenue, it is perhaps not surprising how the federal government and many states have begun looking for ways to measure the community benefit of charitable organizations to justify their continued exempt status, whether through the courts or otherwise.

The States' Role—Selected Charitable Property Tax Exemption Cases

In recent years, several states have sought to raise the bar for charitable property tax exemptions through legislative changes and judicial decisions. The following paragraphs describe the courts' involvement.

Alabama. Health care organizations should be cognizant of an increasing trend among the states to consider an organization's sources of funding in determining whether the organization qualifies as "charitable" under state law. The following case illustrates potential issues for health care providers in this context. Two tax exempt upscale retirement communities were denied exemption on the basis that the communities were not charitable under state law.[6]

While the court of appeals acknowledged the plaintiffs' stated policy not to evict any residents based on an inability to pay, the court noted that pre-admission screening ensured that there was only a negligible risk that any resident would become unable to pay. The court also noted that the retirement communities were constructed without public or private contributions. Interestingly, the court supported its decision by reference to a nearly 30-year old IRS revenue ruling, which held that an elderly housing facility may charge residents substantial fees and retain its charitable character so long as (1) the housing remains within the reach of a significant segment of the community's elderly persons; (2) the organization operates the housing at the lowest feasible cost; and (3) the organization maintains in residence those tenants who become unable to pay its monthly fees.[7] The court found that the two retirement communities failed to meet the tests in the revenue ruling.

Connecticut. A tax exempt skilled nursing facility owned by the Roman Catholic Diocese of Norwich was denied exemption as not being organized and used exclusively for charitable purposes under state law.[8]

In denying the exemption, the superior court noted that the diocese incurred no financial burden from the facility's opera-

tion, the facility's income exceeded its expenses, the facility made lease payments to the diocese, and the facility did not admit indigent patients—patients were either self-supporting, or covered by the Medicare or Medicaid.

Illinois. The Illinois Appellate Court reversed a circuit court's decision in *Provena Covenant Medical Center v. Department of Revenue*[9] and held that a tax exempt hospital was not entitled to an exemption from property tax as a charitable organization.

The battle began in 2006 when the Illinois Department of Revenue denied the hospital's request for an exemption for 2002 on the basis that it was not used exclusively for charitable purposes under state law.[10] In so doing, the Department contended that the hospital's charitable activities constituted less than 1 percent of its revenues; the hospital's charitable care policy did not consider the medical services rendered, the amount of the patient's bill, the financial ability of the patient with respect to the bill; the hospital failed to make any material effort to publicize the availability of charity care to those most in need of it; and the hospital's funds were not derived mainly from public and private charity—in other words, the Department determined that the use of the property was for the exchange of services for payment and not for charity. The Department also determined that Medicare and Medicaid shortfalls did not serve as a basis for charity care. A year later, a county circuit court reversed the Department's decision and allowed the exemption on the grounds of religious and charitable use. The Department appealed to the appellate court.

For its part, the appellate court reversed the circuit court decision. The court concluded that the hospital property was not entitled to an exemption because the hospital, among other issues, did not (1) lessen the burdens of government; (2) receive funds primarily from private and public charity; (3) dispense charity to all who needed and applied for it (without placing obstacles in their way); and (4) exclusively use the property for charitable purposes, which the court defined as the giving of something of value for free. In so doing, the court recognized but rejected calls to establish a fixed percentage by which to measure charity care. The court's decision included many references to the increasingly high cost of health care and historical uses of the term "charity" (stating that "[c]harity is more than rhetoric" and declining to further dilute its meaning beyond the slippage that began long ago). In any event, the saga continues after the Illinois Supreme Court agreed in November 2008 to hear the hospital's appeal and parties brief the case for the Illinois Supreme Court.[11]

In early February, the American Hospital Association (AHA) entered the fray by filing a 40-page amicus brief with the Court in support of the hospital. The AHA argued that (1) nonprofit hospitals lessen the burdens of government by providing a safety net that ensures access to health care for indigent persons or persons enrolled in Medicare and Medicaid even when that care is uncompensated or fails to cover the hospitals' costs; (2) the Department's "free care" test is too narrow a view of nonprofit hospitals' charitable purposes because it ignores the community programs and outreach, medical research and special programs conducted by many hospitals; and (3) imposing property taxes on nonprofit hospitals would seriously impair their ability to provide their communities with needed care.

In another Illinois case, a tax exempt medical clinic was denied a charitable property tax exemption on the basis that the property was used only 27 percent of the time to provide free or reduced fee health care to a medically underserved community and, therefore, was not used exclusively for charitable purposes under state law.[12] The remaining 73 percent of the time, the property was used for the purposes of a tax exempt medical clinic.

Indiana. A tax exempt outpatient medical center was denied an exemption on the basis that the medical center was not predominantly used for charitable or charitable purposes under state law.[13] The tax court took issue with the property owner's claim that the true beneficiary of an exemption would be its tax exempt tenant, who would then have additional capital and human resources to improve its charitable care and medical student educational missions. According to the court, the correct test for exemption was not the distribution of income for charitable purposes but rather whether the property was used predominantly, or more than 50 percent of the time, for charitable and educational purposes (e.g., in this case, to provide free or reduced fee health care or to educate medical students). The court also noted that medical center's "doors were open during normal business hours to *potentially* serve those who were indigent" (italics in original).

Kansas. Health care entities should also consider the degree to which free or reduced fee services are provided to its own beneficiaries. The following case highlights an important distinction that states are beginning to follow. A low income housing facility, operated by a tax exempt general partner to serve homeless persons and persons of low income, was denied a constitutional charitable exemption because the facility was not used exclusively for charitable purposes.[14]

Specifically, the court found that the property owner was "not making a free gift of housing" but rather received compensation from the residents or the federal government in the form of subsidized rents. In cases in which the residents were unable to pay rent with their personal funds or government vouchers, the residents were transferred or referred to a homeless shelter or other agency. This did not meet the general requirement under Kansas case law that a charity provide its services free or charge or nearly free of charge.

Michigan. On the other hand, after many years in court, two tax exempt medical centers were held to be charitable institutions under state law and eligible for property tax exemptions.[15]

Both of the decisions relied on two "indispensable" principles set forth by the Michigan Supreme Court in making determinations as to whether an organization was a charitable institution. First, charitable status requires an evaluation of the overall nature of an institution and not its specific activities. Second, a charitable institution cannot discriminate within the group of persons who need the type of charity it offers. In setting forth its principles, the Court rejected as an "artificial parameter" a percentage threshold of time or resources devoted to charity. Beyond that, the Court also articulated several factors to describe a charitable institution: (1) a nonprofit institution; (2) organized chiefly for charity; (3) does not discriminate among members of the group it serves; (4) brings people's hearts or minds under the influence of education or religion; relieves people from disease, suffering or constraint; assists people to establish themselves for life; erects or maintains public buildings or works; or otherwise lessens the burdens of government; (5) charges for its services no more than is needed for its successful maintenance; and (6) is an institution the overall nature of which is charitable.

North Carolina. As discussed in the Kansas case, the trend among states has been to consider the degree to which an organization provides free or reduce fee services to its beneficiaries. Health care organizations should plan accordingly, as illustrated in the following case, because there is also an increasing trend of lack of deference by states in property tax matters to federal income tax determinations of charitable status. A nonprofit foundation that operated a summer camp and winter school was denied a property tax exemption because, in part, the foundation was not a charitable association or institution.[16]

In so holding, the court of appeals noted that the foundation charged market rents for the summer camp and that only about 2 percent of the camp's revenues were used for financial aid. Moreover, the winter school was open to selected high school students and charged $15,000 per semester. The court rejected as insufficient the facts that the foundation's articles of incorporation and bylaws required the foundation to use its funds exclusively for charitable purposes and that the foundation was exempt from federal income taxation under Section 501(c)(3) of the Code. While acknowledging that the statutes failed to define "charitable association" or "charitable institution," the court nevertheless noted that "charitable purpose" was statutorily defined as a purpose "that has humane and philanthropic objectives" that "benefits humanity or a significant rather than limited segment of the community without expectation of pecuniary profit or reward."

Ohio. A nonprofit psychiatric institute was denied a property tax exemption, for the portion of its property that it leased to a behavioral health center, because it did not qualify as a charitable institution.[17]

The lessor contended that it was entitled to a conclusive presumption that it was a charitable institution on the basis of its federal exemption under Section 501(c)(3) of the Code and on the basis that it was organized to hold and lease real property to another charitable institution. The lessor also contended that it could tie all of the leasehold income from the lessee to the lessee's share of building maintenance costs, and that the lessee ultimately controlled the lessor and, thus, derived all the economic benefits of the lease. The Ohio Supreme Court declined to consider the first issue on the grounds that the lessor failed to create jurisdiction to obtain relief. With respect to the second issue, the Court stated that it had previously held that the charitable institution status depended upon the "charitable activities of the taxpayer seeking the exemption, not the charitable nature of the institutional customers." The Court noted that a "clear corollary" of that precedent was that an institution claiming an exemption for leasing property to another institution must first establish its own charitable activities, and not those of the lessee. The Court added that the lessors engaged in ongoing business activities of leasing (including leasing property to other tenants without regard to cost) and providing staffing services, and that applying the proceeds from those activities to charitable purposes was insufficient. Accordingly, the Court held that both the lessor and the lessee of real property must be charitable institutions to qualify for exemption.

Oregon. It is important to note that more and more courts are applying a mathematical approach to measuring charitable gift and giving, and burdens of government (which may exist only to the extent that the government is unable to charge a user fee to cover its costs). Health care organizations should be aware of the potential application of this approach to their own entities in the following case. A nonprofit on-campus public university bookstore was denied a property tax exemption because its activities were not charitable in nature and the "requisite gift and giving" was lacking.[18]

The parties agreed that the Oregon law established three elements to qualify as a charitable institution: (1) charity must be the organization's primary, if not sole, object; (2) the organization must perform in a manner that furthers its charitable object; and (3) the organization's performance must involve a gift or giving. The court noted that of the three elements, the crucial consideration is that of gift or giving. The bookstore contended that it met the third element by funding textbook scholarships, donating cash and merchandise, participating in a federally mandated assistance program for disabled students attending the university, and that it lessened governmental burdens by operating a bookstore that may otherwise have to be operated by the state. The court, however, noted that the bookstore's gift and giving accounted or less than 0.5 percent of its total revenue, that its textbook scholarships benefited only 160 of the university's 24,000 students, and that it did not use a sliding scale for the sale of books and merchandise based on ability to pay. Moreover, the court was unconvinced that the bookstore lessened governmental

burdens because the bookstore was presumably self-funding and, therefore, it was not clear that the government would bear any burden by operating the bookstore.

The Federal Role—the IRS Revises Form 990

Even the federal government has begun to look for ways to measure the community benefits provided by charitable organizations. Specifically, building on the efforts of Senators Max Baucus (D-Mont.) and Chuck Grassley (R-Iowa) of the U.S. Senate Committee on Finance, the Service has overhauled the Form 990 that will be filed by tax exempt organizations beginning in 2009.[19]

The new Form 990, a complete discussion of which is beyond the scope of this article, will require tax exempt organizations to provide extensive information on corporate governance, executive compensation and the organization's relationships with other entities. In addition, hospitals will be required to complete a new schedule that requests information on community benefit activities, billing and collection activities, management and joint ventures. The information will be used to design and guide the IRS's future compliance and enforcement activities.

Recommendations

More than ever, it is no longer business as usual for our nation's tax exempt organizations, some of which may experience increased scrutiny by the states in which they operate. Accordingly, organizations should be proactive.

- Establish, review and update charity care or financial assistance programs to ensure consistency with the organization's stated mission and organizational documents.
- Avoid heavy-handed billing and collection practices.
- Publicize the availability of charity care or financial assistance programs (e.g., brochures, signage or enclosures mailed with billing statements).
- Maintain records of the organization's contributions to the community, especially programs that are provided free of charge or for fees below cost (e.g., health screenings, health fairs, employee volunteer commitments), including the cost to provide such programs.
- Educate employees about the organization's mission, and commitment and contributions to the community.
- Develop relationships with the local media to help create an awareness and understanding of the organization's contributions to the community.
- Consider the costs of litigation over exemption challenges and agreeing to make a payment-in-lieu-of-tax.
- Improve corporate governance to ensure compliance with the federal and state regulations that apply to charitable organizations (e.g., conflicts of interest, whistleblower, and document retention policies; executive compensation; excess benefit transactions; charitable solicitations), not just the regulations that apply to certain licensed facilities or organizations.

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1 For the purposes of this article, "charitable organizations" and "tax exempt" refers to organizations that are exempt from federal income taxation under Section 501(c)(3) of the Internal Revenue Code of 1986, as amended, excluding private foundations, religious organizations and organizations with annual revenues of less than $25,000.

2 Internal Revenue Service, Statistics of Income Division, *Nonprofit Charitable Organization and Domestic Private Foundation Information Returns, and Exempt Organization Business Income Tax Returns: Selected Financial Data, 1985-2004* (Oct. 2007), http://www.irs.gov/pub/irs-soi/histab16e.xls.

3 *Id.*

4 Paul Arnsberger, Special Projects Studies Section, Internal Revenue Service, *Charities, Social Welfare, and Other Tax-Exempt Organizations*, 2004 (Statistics of Income Bulletin Fall 2007).

5 Alicia Meckstroth and Paul Arnsberger, *Special Projects Studies Section, Internal Revenue Service, A 20-Year Review of the Nonprofit Sector*, 1975-1995 (Statistics of Income Bulletin Fall 1998).

6 *Surtees v. Carlton Cove, Inc.*, 974 So. 2d 1013 (Ala. Ct. App. 2007).

7 Rev. Rul. 79-18, 1979-1 C.B. 194.

8 *St. Joseph Living Ctr., Inc. v. Town of Windham*, No. CV-04-0072963S, 2007 Conn. Super. LEXIS 585 (Conn. Super. Ct. Feb. 23, 2007).

9 *Provena Covenant Med. Ctr. v. Dep't of Revenue*, 384 Ill. App. 3d 734, 894 N.E.2d 452 (2008).

10 *Dep't of Revenue v. Provena Covenant Med. Ctr.*, Docket No. 04-PT-0014 (Ill. Dep't of Revenue, Sept. 29, 2006), http://www.revenue.state.il.us/legalinformation/hearings/pt/pt06-26.pdf.

11 Answer to Petition for Leave to Appeal, The Department of Revenue of the State of Illinois, No. 107328.

12 *Cmty. Health Care, Inc. v. Ill. Dep't of Revenue*, 369 Ill. App. 3d 353, 859 N.E.2d 1196 (2006).

13 *HCPI Ind. LLC v. Hamilton County*, 867 N.E.2d 713 (Ind. Tax Ct. 2007).

14 *In re Inter-Faith Villa, L.P.*, Docket. No. 97,728 (Kan. Ct. App. June 6, 2008), 2008 Kan. App. LEXIS 91. The court also considered and rejected statutory tax exemptions for low income housing and humanitarian services; another statutory tax exemption for charitable organizations, which allows reimbursement for charitable services, was not considered because it was not raised by the property owner during the proceedings.

15 *Wexford Med. Group v. City of Cadillac*, 474 Mich. 192, 713 N.W.2d 734 (2006); *McLaren Reg'l Med. Ctr. v. City of Owosso*, 275 Mich. App. 401, 738 N.W.2d 777 (2007).

16 *In re Eagle's Nest Found.*, No. COA08-316, 2009 N.C. App. LEXIS 5 (N.C. Ct. App. Jan. 6, 2009).

17 *Northeast Oh. Psychiatric Inst. v. Levin*, Slip Opinion No. 2009-Ohio-583.

18 *Portland State Univ. Bookstore v. Multnomah Assessor*, No. TC-MD 060824C, 2009 Ore. Tax LEXIS 27 (Or. Tax Jan. 29, 2009).

19 The new Form 990 and schedules may be viewed at http://www.irs.gov/charities/article/0,,id=181093,00.html.

Privacy

HHS' physicians' Medicare billing records not subject to FOIA request

A consumer information organization was not entitled to HHS' records for all Medicare claims submitted by HHS physicians during 2004 because the records are exempt from disclosure under the Freedom of Information Act (FOIA), the U.S. Court of Appeals for the District of Columbia Circuit concluded. The organization had requested a subset of data elements from all Medicare claims by certain physicians in 2004 that included the diagnosis, the type and place of service, and the unique physician identifying number (UPIN) of the physician who performed the services in the District of Columbia, Illinois, Maryland, Washington, and Virginia.

The organization argued that disclosure of the records would serve the public interest by revealing information about HHS': (1) performance in maintaining and enhancing the quality and efficiency of services provided under the Medicare program; (2) ability to root out Medicare fraud and waste; and (3) compliance with various transparency initiatives.

FOIA exemption. Although disclosure, not secrecy, is the policy objective of FOIA, one of the specific exemptions from this policy is the privacy exemption. The exemption states FOIA does not apply to personnel and medical files and similar files the disclosure of which would constitute a unwarranted invasion of personal privacy as stated in 5 U.S.C. §552(b)(6).

The court concluded that the information request would reveal the total Medicare payments received by a physician for covered services and that physicians' have a substantial privacy interest in total payments they receive from Medicare. Further, the requested data did not serve any FOIA-related public interest in disclosure and there was no need to balance a nonexistent public interest against a physician's substantial privacy interest in the Medicare payments he or she receives. ■

Consumers' Checkbook v. HHS, D.C. Cir., Jan. 30, 2009, Health Care Compliance Letter, 800,614

In the News

Improper drug marketing allegedly violates FCA

A recently unsealed civil complaint alleges that a New York pharmaceutical company engaged in improper marketing practices for two antidepressant drugs, Celexa and Lexapro, promoting them for unapproved pediatric use and paying kickbacks to induce physicians to prescribe them. Forest Laboratories, Inc., allegedly provided physicians with various forms of illegal remuneration, including cash payments disguised as grants or consulting fees, expensive meals and entertainment. The complaint was unsealed in the U.S. District Court in Massachusetts following an investigation by several federal agencies. It alleges that Forest Laboratories actively promoted the pediatric use of the drugs and misled physicians by failing to disclose the results of a study that found Celexa to be no more effective than a placebo. In the same study, more patients taking Celexa reported suicidal thoughts than those taking a placebo. The complaint alleges that the company's improper promotional practices caused thousands of false and fraudulent claims to be submitted to federal health programs in violation of the False Claim Act.

United States Attorney's Office News Release, Feb. 25, 2009

DME supplier sentenced in illegal kickback scheme

The owner of a medical equipment supply company was sentenced to five years in federal prison after he pleaded guilty to paying illegal kickbacks. Walter Sanders, of Mesquite, Texas, engaged in a scheme with his former wife, who was then employed as a secretary in the emergency department of a Memphis hospital. According to court documents, Sanders paid for Medicare patients' identifying information, which he then sold to other medical equipment suppliers, who used the data to submit false claims to Medicare seeking reimbursement for providing power wheelchairs to Medicare beneficiaries. More than 200 fraudulent claims were submitted because of Sanders' scheme. In addition to the prison sentence, Sanders was ordered to pay restitution to Medicare totaling more than $804,000. Sanders former wife, Geneva Sanders, was sentenced in November to 16 months in prison and ordered to pay more than $132,000. Many of the medical equipment suppliers who participated in the scheme have been indicted or are serving sentences.

Department of Justice News Release, Feb. 19, 2009

Obama nominees to lead health reform effort

President Obama nominated Kansas Governor Kathleen Sebelius as HHS Secretary and health care expert Nancy-Ann DeParle as head of the White House Office of Health Reform. Obama also announced the release of $155 million authorized by the American Recovery and Reinvestment Act that will support 126 new health centers. The centers will largely serve people in need, including many with no health insurance. Sebelius, elected twice in a Republican-dominated state, has been praised for her willingness to do battle with the insurance industry. DeParle handled budget matters for federal health care programs under the Clinton administration. The two are expected to lead the president's effort to pass extensive health care reform. "Health care reform that reduces costs while expanding coverage is no longer just a dream we hope to achieve—it's a necessity we have to achieve," Obama said.

CCH Chicago Bureau, March 3, 2009