CCH Health Care Compliance LETTER

Volume 11, Issue 10 health.cch.com May 13, 2008

CMS focuses on hospital quality in FY 2009 IPPS proposed rule

CMS continued to demonstrate its commitment to improving the quality of care provided to Medicare beneficiaries in the nation's hospitals by including in the fiscal year (FY) 2009 inpatient prospective payment system proposed rule several provisions that would strengthen the connection between quality and payment for hospital services by tying reimbursement to improved quality reporting.

"CMS is taking aggressive actions to ensure that beneficiaries get safe, high quality, and efficient care from their health care providers, and the actions we are announcing...build on our efforts," CMS Acting Administrator Kerry Weems said in a related press release.

Quality initiatives. CMS continues to apply value-based purchasing (VBP) tools to transform itself from a passive payer to an active purchaser of high quality health services. Numerous studies have documented the detrimental effects on patients and the increased costs of health care services resulting from a preventable injury or condition acquired due to hospital errors. Perhaps the best known study was the 1999 Institute of Medicine report *To Err is Human: Building a Safer Health System*, which estimated that medical errors, including hospital acquired conditions (HACs), may be responsible for as many as 98,000 deaths annually, at costs of up to $29 billion.

Hospital acquired conditions. One such VBP tool that CMS has begun to utilize is the HACs initiative. Beginning October 1, 2008, Medicare will no longer pay hospitals for the increased costs of care that result when a patient is harmed by one of several conditions that did not exist when the patient was first admitted to the hospital and that were reasonably preventable by following generally accepted guidelines. Under the proposed rule, CMS would refine two of the previously selected HACs by: (1) including ICD-9-CM code 998.7(CC) for an acute reaction to a foreign substance accidentally left in during surgery; and (2) modifying the pressure ulcer codes to capture staging information.

In addition, CMS has proposed expansion of the list of conditions that must be reported if present on admission (POA). The revised list would include: (1) surgical site infections following elective procedures; (2) Legionnaires' disease; (3) glycemic control (extreme blood sugar derangement); (4) latrogenic pneumothorax; (5) delerium; (6) ventilator associated pneumonia; (7) deep vein thrombosis/pulmonary embolism; (8) staphylococcus aureus septicemia; (9) clostridium difficile associated disease (CDAD). If adopted, these additions would bring the total number of conditions that must be reported upon admission to seventeen.

continued on page 2

Wolters Kluwer Law & Business

"When these conditions occur during a hospital stay, the patient and his or her family suffer needlessly. To make matters worse, these conditions are likely to result in higher medical bills for the family to pay for additional services for physician care, prescription drugs, and other items and services that would not have been necessary if proper care had been provided," Weems noted. "Medicare can and should take the lead in encouraging hospitals to improve the safety and quality of care and make better practices a routine part of the care they provide not just to people with Medicare, but to every patient they treat."

With limited exceptions, CMS has indicated in the proposed rule that the "U" indicator (documentation insufficient) will be treated like the "N" indicator (not POA) on the POA form. CMS expects that not paying for the comorbid condition (CC) and major comorbid condition (MCC) Medicare severity diagnosis related groups (MS-DRGs) for HACs coded with the "U" indicator will help foster better medical record documentation.

Quality data reporting. The proposed rule also contains a provision that would expand the hospital quality measures reporting program, which reduces the amount a hospital is paid if it does not participate in the reporting of standardized reporting measures. These are measures that are publicly reported on HHS' Hospital Compare Web site at http://www.hospitalcompare.hhs.gov.

For FY 2009, CMS is proposing to add 43 additional quality measures, bringing the total number of quality measures a hospital must report to get the full inflation update for FY 2010 to 73. The proposed additions include the following types of measures:

- one Surgical Care Improvement Project (SCIP) measure;
- three hospital readmissions measures;
- four nursing care measures;
- five Patient Safety Indicators developed by the Agency for Healthcare Research and Quality (AHRQ);
- four Inpatient Quality Indicators developed by the AHRQ;
- six venous thromboembolism measures;
- five stroke measures; and
- 15 cardiac surgery measures.

Based on all available information, CMS predicts a market basket update of 3.0 percent for FY 2009 for those hospitals that report on all quality measures. Pursuant to the Deficit Reduction Act of 2005, hospitals that report all required quality measures in 2008 will receive the full 3.0 percent update. Those that fail to report the quality measures in 2008, however, will receive a reduced update of 1.0 percent.

Other changes. Regarding physician disclosures, CMS has proposed to: (1) specify the time frame for disclosure of physician ownership to patients as the time that the list of owners and investors who are physicians (or immediate family members of physicians) is requested by or on behalf of the patient; and (2) require hospitals to condition physicians' continued membership on the medical staff or admitting privileges on the physicians' written disclosure to all patients they refer to the hospital any ownership or investment interest the physicians or their immediate family members have in the hospital.

The proposed rule also would clarify the Emergency Medical Treatment and Active Labor Act (EMTALA) regulations for specialized hospitals by amending 42 C.F.R. §412.24(f) to add a provision stating that when an individual covered by EMTALA is admitted as an inpatient and remains unstabilized with an emergency condition, a receiving hospital with specialized capabilities has an EMTALA obligation to accept that individual assuming the specialized hospital has the capacity to treat the individual.

CMS also has proposed that hospitals may comply with EMTALA's on-call list requirements by participating in a formal community call plan so long as the plan meets certain requirements.

In addition, the proposed rule contains several proposals related to the Stark II "stand in the shoes" provisions of CMS' Final rule released on September 5, 2007 (73 FR 51012, ¶700,047). *See* "CMS proposes 'stand in the shoes' alternatives," *Health Care Compliance Letter*, Vol. 11, Issue 9 for a discussion of the stand in the shoes proposals contained in the FY 2009 IPPS proposed rule.

The proposed rule was published in the *Federal Register* on April 30, 2008. Comments on the proposals will be accepted through June 13, 2008. ■

CMS Press Release, April 14, 2008; Proposed rule, 73 FR 23528, April 30, 2008.

CCH Health Care Compliance Letter

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CCH Health Care Compliance Letter is published 24 times a year by CCH, a Wolters Kluwer business, 4025 W. Peterson Avenue, Chicago, IL, 60646. Subscription rate is $305 per year. First-class postage paid at Chicago, Illinois, and at additional mailing offices. POSTMASTER: SEND ADDRESS CHANGES TO *CCH Health Care Compliance Letter*, 4025 W. PETERSON AVENUE, CHICAGO, IL 60646. Printed in U.S.A.

FCA claim fails against hospital qualified for AMC exception

A group of pediatric cardiologists, a medical school, and a pediatric hospital did not submit false claims to the Medicaid program by violating the prohibition on physician self referral under the Stark law (Social Security Act §1877) because they qualified for the academic medical center (AMC) exception.

Background. The cardiologists practiced at Kosair Children's Hospital in Louisville, Kentucky and were faculty members of the University of Louisville Medical School. Through an arrangement with the medical school, all full-time faculty pay a portion of their private practice earnings to the school, which uses the money to pay for faculty salaries.

In addition to the money it receives from faculty, the school receives donations from Kosair Children's Hospital. In turn, Kosair applies for reimbursement for eligible patients from Medicaid and certifies that it is eligible to receive Medicaid reimbursement.

A former member of the pediatric group, who also was a faculty member, brought a *qui tam* suit alleging violations of the False Claims Act (FCA). The *qui tam* provisions of the FCA allow private citizens, known as relators, to file suit on behalf of the government and share in a percentage of any recovery. The core of the relator's allegations was that the hospital's certification of compliance with applicable law and the related claims were false because of the improper referrals between the cardiologists and the hospital.

The AMC exception. Under the AMC exception, referring physicians must: (1) be employed by the medical school on a full- or part-time basis as "*bona fide* employees;" (2) be licensed as medical doctors in the state in which they practice; (3) have received a "*bona fide* faculty appointment" to a medical school; and (4) have spent at least 20 percent of their time or eight hours per week as an academic or provider of clinical teaching services. 42 C.F.R. §411.355(e).

Under 42 C.F.R. §411.355(e)(1)(ii), physicians who serve as educators must be paid fair market value for their services, such that they "are paid based on the value of their work rather than the value of their referral business to the hospitals." This fair market value does not include income that physicians receive from private practice because such income "falls well outside the scope of the Stark law's prohibition on self-referrals," the court said.

Analysis. The physicians received salaries from the school that were at or below the market value of salaries for medical school faculty, the court found. Also, their salaries did not always rise along with the amount of business they generated for the hospital, contrary to the relator's arguments. The court determined that the defendants' financial arrangement was not an "illegal referral scheme" prohibited by the Stark law, but rather an arrangement allowed by the AMC exception. The members of the cardiology practice performed substantial work as medical school faculty, including supervision of residents and clinical work in the hospital. Their salaries were not tied to inpatient revenue generated for the pediatric hospital.

The relator also argued that there was neither a written agreement that solidified or perpetuated the relationship between the school and Kosair, nor a "course of conduct that...appropriately documented" the relationship between the school and Kosair as required by the Stark regulations. The court decided that the relationship between the school and Kosair was not required to be documented by a single document and that there was sufficient documentation of a "course of conduct" and a relationship between the school and Kosair.

Although the relator alleged that the physicians, medical school, and hospital violated the anti-kickback statute, he failed to present any facts that they violated the law. The court noted that the anti-kickback statute and Stark law do not allow a private right of action, and the *qui tam* provision of the FCA, which allows private persons to bring civil claims for violation of the FCA, does not authorize private persons to bring civil claims for violations of the anti-kickback and Stark laws *outside* the context of the FCA. ■

U.S. ex rel. Villafane v. Solinger, W.D. Ky., April 8, 2008, Health Care Compliance Reporter ¶800,487.

Compliance begins at the top: 20 questions and answers about compliance

by Mark D. Olson, Esq., Contributing Editor

"The main thing about money, Bud, is that it makes you do things you don't want to do." Lou Mannheim (Hal Holbrook) to Bud Fox (Charlie Sheen) from the film Wall Street (1987).

The start

A company's "culture" comes directly from its executive suite. The actions of individuals at the top define conduct expected or permitted throughout the organization. If employees look to senior leadership and see excessive personal use of the company's money, nobody should be surprised when others working for the company bend the rules.

Health care fraud was a multi-billion dollar business last year and will be for the foreseeable future. Already in 2008, large fraud settlements have been announced, including Merck agreeing in February to pay $650 million after acknowledging pricing fraud related to three of its most popular drugs (Vioxx®, Zocor®, and Pepcid®).

Misappropriation of money intended to care for people who need health services is one of those acts that defies explanation. How does one rationalize the taking of money intended to pay for health services for personal use and luxuries? Given the billions taken each year, the answer appears to be "with relative ease."

An effective compliance program is the first line of defense in ensuring the proper use of health dollars. The following questions and answers will explore whether current compliance programs are effective, what unique challenges compliance officers face, and what key components should be present in any good compliance program.

Twenty questions and answers

1. Can health care fraud be prevented?

Yes, but preventing fraud in the health care context takes work. The easy part is drafting compliance manuals. The hard part is implementing an effective program.

No program will be effective without open communication channels between compliance offiders and employees. Despite the difficulty, the task of creating and maintaining communication channels throughout an organization is crucial to an effective compliance program.

To be successful, a compliance officer must earn the trust of the department heads and staff. Any employee communicating what he or she believes to be a compliance problem needs to know that his or her concerns are taken seriously. All such communications must be thoroughly investigated. In addition, the reporting employee needs to know, at the proper time, the results of the investigation.

Failure to give attention to staff concerns virtually guarantees that information sources all over the hospital will close. Once closed, these channels are extremely difficult to reopen, and, as a practical matter, the effectiveness of the incumbent compliance officer can be permanently compromised.

2. Why so much fraud today?

One very important reason is the move away from nonprofit and charitable principles in running a nonprofit provider. The pressures to perform are large and made more difficult by relatively lean managed care reimbursement contracts. Executive and department head compensation is now frequently based on profits. Those pricing pressures encourage providers to become creative at maximizing revenues and profits.

3. Who generally uncovers information leading to a fraud prosecution?

Almost every important health care fraud prosecution, civil or criminal, results from tips from an employee or independent contractor. An effective compliance program should result in the chief compliance officer getting the information before the insider heads for the authorities, and that begins with communication channels. Employees and contractors almost always try to fix matters in house first. Whistleblowers understand that exposing fraud to prosecutors has a big downside.

4. What is the downside to becoming a whistleblower?

Speaking out against perceived misconduct can be a long and difficult journey for a whistleblower. Whatever the eventual recovery, the price of becoming a relator is much higher than the public might imagine. Once a case is unsealed, the whistleblower's network of friends

at work disappears and he or she may become ostracized by co-workers who view them as traitors. The workplace environment may even become so unbearable that the "tattler" is forced to quit.

Many whistleblowers are no longer employable in the health care business, at least in the metropolitan area or region where they currently live. The whistleblower can become a pariah both inside and outside the organization, even though the wrong exposed may have caused great harm if left unchallenged. By any objective standard, the monetary reward for a whistleblower, if any, usually comes at a large personal cost.

5. If money is not the principal reason, what motivates whistleblowers?

Surprisingly, it is not a pursuit of financial gain, but rather genuine concern over perceived wrongdoing and the frustration of being ignored that motivates most whistleblowers to seek redress outside the organization. Very few whistleblowers run to an attorney without first attempting to communicate their concerns to management on at least one or two occasions. Management indifference is what drives (by a good distance) more concerned employees into the arms of attorneys and government prosecutors.

"Failure to give attention to staff concerns virtually guarantees that information sources all over the hospital will close. Once closed, these channels are extremely difficult to reopen, and, as a practical matter, the effectiveness of the incumbent compliance officer can be permanently compromised."

6. Isn't the whistleblower afraid of losing his job?

Typically, whistleblowing happens in two steps. First, the employee talks to management about what he or she perceives to be a serious problem within the organization. At this point, blowing the whistle is not even on the employee's radar screen. But the employee soon learns that by bringing concerns about questionable behavior to senior management, the individual has damaged his or her relationship with the boss or supervisor. Many employees who take Step 1 find, much to their shock and surprise, that senior managers are not that thrilled with the disclosures. The concerned employee no longer is seen as a "team" player. This is when the job loss fear becomes very real. As the employee's relationship with superiors and co-workers weakens, he or she proceeds to step two—complaining to the U.S. Attorney or HHS Office of Inspector General. When that step is taken, the employee (now a whistleblower) knows that his or her job is gone.

7. Where should a compliance officer look for possible fraudulent practices?

The first stop is compensation (employment agreements) and expense accounts of senior executives and members of the board. The next step would be to review compensation "incentives" or bonus plans for vice presidents and department heads.

8. Why start with executive compensation and incentives?

The executive suite sets the tone and culture for the business. What is acceptable and unacceptable in terms of business practices and how the resources of the business can be used starts there.

One of the best recent examples involves former executives of Tenet Healthcare. In a complaint filed by the Securities and Exchange Commission (SEC) in 2007, a number of senior Tenet executives were accused of receiving millions of dollars in unearned compensation via discretionary bonuses for strong yearly earnings growth from 1999–2002.[1] The SEC alleged that the company's earnings growth was inflated due to Tenet's exploitation of a loophole in the Medicare reimbursement system through which Tenet artificially inflated outlier payments by increasing its gross charges.[2] The complaint also accused the executives of capitalizing on Tenet's artificially high stock price to the tune of millions of dollars.

It is rare that a hospital or health system will have a large fraud problem (or any fraud problem at all, for that matter) if the board controls, monitors, and establishes fair numbers for executive compensation and perks. If greed is a significant factor in the executive suite, those lower on the money chain will want theirs too, and they will figure out a way to get to the money trough.

A good litmus test of executive compensation is to lay out all the salaries and perks, including some detail on expenses reimbursed, in front of the board as if the numbers would be published in the local press. If the faces around the boardroom table start turning red, the compensation system is heading in the wrong direction, if not already out of control.

9. Are the "greed" issues now being addressed?

Yes. Many executive employment contracts now provide that "personal conduct" standards can result in termination. For example, one executive employment contract I was involved in negotiating states that the executive will "act in a moral and ethical manner in all personal and financial dealings with the

hospital board" and "avoid personal conduct that may bring disrepute to the Hospital." These "personal responsibility" and "good conduct" provisions are becoming more and more common, the purpose being to give the hospital board more flexibility. The same is happening in revisions to board conduct rules giving the board more ability to remove or resolve a conflict of interest problem.

10. Are compliance programs effective?

In general, compliance programs are more effective than people realize. Measuring success, however, can be difficult. The problem for even the best compliance officer is that it is very difficult to measure prosecutions that never happen. The value of an effective compliance program can only be appreciated over a period of years.

The issue with companies that are serial offenders is cultural. Defrauding government programs happens because: (a) there is a direct benefit to the employees who created and continue the fraud; and (b) there is tacit approval for the behavior in the executive suite and the boardroom.

"When compensation is tied to profits from health services, the ground for fraud is fertile."

11. Are in-house compliance seminars effective?

Any forum that allows for dialogue between compliance staff, vice presidents, department heads, and physicians is a major plus. Visibility is a key element of any successful compliance program. There is much truth to the cliché, "out of sight, out of mind." An effective compliance staff must be hands-on, meeting with all hospital departments' key personnel and nursing staff, employees with purchasing responsibilities, and finance staff. Equally important is having visibility with the medical staff. The dreaded seminar also is a helpful tool in getting in front of people, particularly new employees.

12. What are some of the more difficult issues for the compliance officer to address?

Organizational favoritism—situations in which a select few get great benefits and those not in the favored class get none—is difficult to address. This is the first cousin to the "ignored employee" problem. Those receiving special personal benefits are often senior employees or very important physician-admitters. Employees know that crossing superiors or important admitters, even those who are abusing company dollars, is a quick way to the front of the "no future here" line.

13. What is the value of communications with the medical staff?

The key to gaining a physician's confidence is to be perceived as competent and, if a chance to appear as part of a clinical department program or medical staff function presents itself, take advantage of the opportunity. Continuing education is as much about building visibility, confidence, and trust as it is about education.

The overwhelming majority of physicians want to do the right thing. Staff physicians also know who their bad apples or potential problems are. The compliance office needs to know that too.

To help develop these communication channels, attend hospital social functions at which members of the medical staff are present. Show an interest in the physicians as people and understand their unique issues and problems. The compliance officer will soon learn how important good relationships with the medical staff prove to be, particularly when there is a problem for which physicians can help or provide information that cannot come from any other source.

14. Why is it difficult for physicians to embrace a compliance program?

Often, compliance programs are rolled out with great fanfare, with meetings being scheduled and manuals being distributed in great earnest. Sometimes the first round of meetings happens, but all too often that first meeting is the last anyone on the medical staff ever hears about the compliance program. The manuals are put on the shelf and quickly forgotten. The physicians view the lack of follow-up as just one more administrative nonprogram. Physicians have no interest in participating or supporting a compliance program that has become an administrative afterthought.

15. What about incentives and bonuses for vice presidents and department heads?

Incentives based on departmental profitability can be problematic because if meeting those incentives means a good bonus check, employees will find some way to qualify. The number of corners employees cut to reach a bonus target almost always will mirror the greed factor in the executive suite.

The concept of "bonus" has evolved into the bonus becoming a more concrete part of the compensation package, and the employee now views "bonus" as part of the total pay for the position and the responsibilities. When a bonus is tied to the profitability of a division or department, everyone understands that those profit numbers need to be met.

This is where institutional culture becomes critical. Numbers can be arbitrary, and good effort and outstanding work product can fall short of a set-in-stone number. If a bonus is significant—and even $5,000 or $10,000 can be very important to the employee—and the bosses abuse company monies in terms of how senior executives take care of themselves, it will not be long before those on the lower rungs will do whatever it takes, even if it is fudging numbers or cutting corners to have those extra dollars of pay during the fiscal year. If people are reasonably within the range of meeting the "target," and it becomes a close call as to whether the department will meet the target or not, corners are cut and numbers are fudged because, at the end of the payday, the dollars are in the pockets of the employees.

Rather than profit target systems, organizations should consider a "merit bonus," or the rewarding of effort and quality performance, even if the numbers produced are not those that had been targeted. The merit bonus approach levels the playing

field in that some departments have (whether because of patient mix or other utilization factors) easier paths to bonuses than others. The problem with "merit" bonus systems is that they often evolve into favorites getting paid while those not "in" with management are ignored. Despite its flaws, the "merit" system offers many more checks and balances than profit target systems.

Transparency in senior executive and department head compensation will eliminate most of the problem. Remember that people cheat only if there is a direct benefit to them. People rarely cheat so that the company will make more money. This is the WIIFM (What's in it for me?) principle in action.

16. What are the early indicators of fraud?

The following arrangements cannot pass the "sniff" test:

- revenue spikes from departments that trigger significant compensation incentives;
- compensation programs with high-end rewards for senior executives;
- lavish spending on perks such as country clubs and travel;
- substantial dollar contracts or payments to physicians for "medical director" services when the relationship of dollars paid to time spent is out of balance; and
- contracts with physicians who are large revenue generators for the hospital or provider (*e.g.*, large "sweetheart" consulting contracts and severance payments for executives who leave.

17. Why are the largest settlements found in for profit health care enterprises?

A persuasive case can be made that the provision of health services should be exclusively a not-for-profit enterprise. Maximizing profit cannot be an integral part of a health care provider's culture because of:

(i) the importance of health services to the community;
(ii) peoples' need to have access to care;
(iii) the many services that need to be provided to those who cannot afford to pay;
(iv) the unpredictable nature of emergency services; and
(v) the need to have resources available on a 24/7 basis.

Health care is a naturally inefficient business. Resources need to be available around the clock, and having those resources available is expensive. Case in point, my children never got sick between 8:00 a.m. and 5:00 p.m., Monday through Friday. They were always at their sickest around midnight or on weekends.

If profit becomes the principal reason for delivery of health services, there are all kinds of ways to generate the "right" patient population or expand delivery of services (whether necessary or not). When compensation is tied to profits from health services, the ground for fraud is fertile.

18. What role does the federal reimbursement system play in health care fraud?

The federal reimbursement system plays a very important role. The Medicare payment system is tailor made for fraud. Where else (besides the Department of Defense) can a business send bills to the government and be paid so long as the billing form is filled out correctly? If a person is not overly greedy, he or she potentially could steal from the Medicare or Medicaid systems forever with very little chance of ever being caught (unless someone blows the whistle).

The enforcement agencies simply cannot do enough auditing, nor do the audits go deep enough, to catch any but the most obvious instances of fraud in the services sector where people are billing for visits and procedures. False billing, done in small quantities in a large practice, upcoding, subtle kickbacks at levels that are very difficult to spot—all can be done in today's enforcement environment without all that much fear of being caught.

19. Are aggressive collection practices indicators of fraud?

Hospitals now aggressively collect their bills, often turning over those who cannot pay and have some assets to collection agencies. The number of bankruptcies caused by unpaid medical bills is huge and getting larger every day. Governing boards that permit or support aggressive collections as a standard business practice usually are more focused on profits than on how the hospital or system is delivering health services.

For example, consider the recent case of Fairview Health Systems in Minnesota, where an audit by the state attorney general, Mike Hatch, revealed lavish executive compensation (including expensive trips and over-the-top dinners) at the same time the company was hiring aggressive collection agents to garnish bank accounts and wages of patients with outstanding medical bills.

20. Are compliance and risk management the same program with different names?

Although there may be some turf wars, the objectives of each are very different. Risk management involves quality of care, insurance, and professional liability. Compliance focuses on operations of a health business in a manner consistent with the many laws and regulations governing billing, relationships with the medical staff, Stark I and II, and the Medicare anti-kickback law and regulations. ■

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[1] The SEC Complaint is available at http://www.sec.gov/litigation/complaints/2007/comp20067.pdf. Tenet entered into a $10 million civil settlement with the SEC to resolve the allegations on April 2, 2007. *See also* "Tenet settles allegations it misled investors," *Healthcare Compliance Letter*, Vol. 10, Issue 8, April 17, 2007.

[2] In June 2006, Tenet agreed to pay the United States $900 million to resolve allegations that it artificially inflated outlier payments by increasing its gross charges. The DOJ press release is available at http://www.usdoj.gov/opa/pr/2006/June/06_civ_406.html. *See also* "Tenet settles FCA allegations for $900m," *Healthcare Compliance Letter*, Vol. 9, Issue 14, July 10, 2006.

Tax-Exempt

Revised Form 990 takes disclosure to new levels, experts caution

Filers of the new IRS Form 990 will find "triggers" in many questions on the core form directing them to give more detailed explanations on various schedules, John Salbego, tax senior manager, Reznick Group, told exempt organizations at a forum on the new form sponsored by Arent Fox LLP and the Reznick Group on May 1, 2008, in Washington, D.C. Answering "no" to any of the questions, could raise a red flag for the IRS, Joseph A. Rieser, partner, Arent Fox, added.

Schedules. The core of revised Form 990 includes 11 parts, Salbego explained. Throughout the core are numerous "yes and no" questions. Part IV alone of the core form asks filers to answer 37 questions. "If you answer yes to a question that puts you in the position of having to complete a schedule." "All of the questions and schedules reflect recent policy debates of whether exempt organizations are furthering their exempt purpose," Rieser said.

Good Governance. Good governance appears to encompass more involvement by the exempt organization's board of directors, Rieser noted. The IRS may be looking for a more "hands-on" approach by directors of nonprofits. They may need to spend the same amount of time that directors of for-profit organizations spend on entity business, he indicated.

One example of the IRS' emphasis on good governance is Question 10 on Part IV of new Form 990, Deanne M. Ottaviano, partner, Arent Fox, explained. Question 10 asks if a copy was provided to the organization's governing body before it was filed. Organizations must describe the process, if any, they used to review the form.

"If the board chooses to delegate (review), it may but it must describe why," Anne E. Schrantz, principal, Reznick Group, said. "Because so many different areas are touched upon the new Form 990, there may be different committees (of the board) that need to take responsibility for reviewing different portions." ■

CCH Washington Bureau, May 1, 2008.

In the News

Special focus facility data added to CMS Web site

For the first time, CMS' Nursing Home Compare Web site will list whether a nursing home is or has been on CMS' special focus facility (SFF) list. The agency's SFF initiative gives heightened scrutiny to nursing homes that have a history of poor performance or repeated violations of state and federal health and safety rules. The SFF initiative was developed to target facilities with a so called "yo-yo" compliance history, *i.e.*, facilities that consistently are providing poor quality of care, yet periodically are instituting enough improvement that they would pass one survey only to fail the next. As of April 2008, there are 134 SFFs, out of about 16,000 active nursing homes. The Nursing Home Compare Web site with the new SFF information can be accessed at www.medicare.gov. In addition to publishing the SFF list, CMS also released its full "2008 Nursing Home Action Plan for Further Improvement of Nursing Home Quality." The plan consists of: (1) consumer awareness and assistance; (2) survey, standards, and enforcement improvement; (3) quality improvement; and (4) quality through partnerships. The 2008 action plan can be found at http://www.cms.hhs.gov/CertificationandComplianc/12_NHs.asp#TopOfPage.

CMS Press Release, April 24, 2008.

FTC issues final order in ENH case

The Federal Trade Commission (FTC) has released its final opinion and order in the Evanston Northwestern Hospital (ENH)/Highland Park Hospital (Highland Park) case that was initiated in 2005. In 2007, the FTC affirmed an administrative law judge decision from two years prior, declaring that ENH's acquisition of Highland Park, its chief rival, would harm competition in the Northern Chicago suburbs. Among other things, the order: (1) requires ENH to establish separate negotiating teams for both inpatient and outpatient services at ENH and Highland Park; (2) requires ENH and Highland Park to use separate negotiations as its status quo approach to negotiations with payors unless a payor specifically elects to opt out and negotiate for all ENH hospitals jointly; and (3) prohibits the ENH and Highland Park negotiating teams from engaging in the negotiations when a payor elects to negotiate jointly for all ENH hospitals.

FTC Press Release, April 28, 2008.

IRS examining 2006 nonprofit hospital survey respondents

Some tax-exempt hospitals that responded to a 2006 Internal Revenue Service (IRS) survey about their charitable activities are under examination, according to Stephen Clarke, tax law specialist with the IRS Exempt Organizations (EO) Division. The survey asked detailed questions about community benefit, especially uncompensated care. The IRS requested information on the number of individuals who received uncompensated care, how much the hospital spent on uncompensated care, and if the hospital treated bad debts as uncompensated care. Clarke reported that the IRS received responses from "99 percent" of the recipients. When asked how many hospitals that responded to the survey are under examination, Clarke declined to give a number or reveal any details.

CCH Washington Bureau, April 25, 2008.