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Letters to the Editor

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HHS issues semiannual agenda of rulemaking decisions

by Sheila Lynch-Afryl, J.D., Contributing Editor

HHS has issued its semiannual publication of all rulemaking actions under development or review, which includes all the proposed rules and final rules that will be issued by HHS in the next 12 months.

Proposed and final rules. In the next 12 months, the Office of the Secretary (OS) expects to issue a proposed rule that would establish a safe harbor with respect to the provision of nonmonetary remuneration for electronic prescribing information technology. Among the final rules OS will be considering are: (1) a new statutory exception for risk-sharing arrangements under the federal health care programs' anti-kickback provisions; (2) standards for the new anti-kickback safe harbor addressing remuneration between federally qualified health centers and certain providers where significant community benefit exists; and (3) clarification of the terms and application of program exclusion authority for submitting claims containing excessive charges.

Long-term actions. A long-term action proposed by OS includes revisions to the regulations addressing the Office of Inspector General's (OIG) authority to impose civil money penalties and assessments. Existing regulatory text would be reorganized and simplified, and obsolete references contained in the current regulations would be eliminated. This proposed rule would establish separate subparts within 42 C.F.R. Part 1003 for various categories of violations and modify the current definition for the term "claim." The timetable for this action has not yet been determined.

Another proposed rule would seek to establish a framework for enforcing compliance with the administrative simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (PubLNo 104-191) through the imposition of civil money penalties. A proposed rule was published April 18, 2005, and the final action is anticipated to take place in August 2006.

An additional proposed long-term action includes revisions to the waiver provisions of the OIG's exclusion authorities to permit any federal health care program to request a waiver of an OIG exclusion imposed under Soc. Sec. Act §1128(a)(1), (3), or (4). The timetable for this action has not yet been determined.

CMS also expects to issue about 32 proposed rules and 15 final rules during this period. The Regulatory Flexibility Act of 1980 and Executive Order 12866 require this semiannual publication. ■

Semiannual Regulatory Agenda, 70 FR 26818, May 16, 2005, ¶191,001

GAO: HHS must establish milestones as it develops a national IT strategy

by Sheila Lynch-Afryl, J.D., Contributing Editor

Although HHS plans to address the goals and strategies of a framework to guide the development of a full strategic plan for national health information technology (IT) adoption, it has not established milestones for the completion of phase I, which it is currently implementing, nor has it made detailed plans for the completion of activities for phases II and III, according to the Government Accountability Office (GAO).

The Institute of Medicine concluded that health care delivery in the U.S. has longstanding problems with medical errors and inefficiencies that increase the cost of health care. In April 2004, President Bush announced a health IT plan that calls for the development of a strategic plan to guide the nationwide implementation of health IT in both the public and private health care sectors to prevent medical errors, reduce costs, improve quality, and produce greater value for health care expenditures.

National health IT strategy. In July 2004, HHS released a framework for strategic actions as a first step toward a strategy to implement a nationwide health IT infrastructure. The framework defines four major goals and 12 strategies that are to be implemented in three phases. These goals include: (1) informing clinical practice with the use of electronic health records; (2) interconnecting clinicians so that they can exchange health information using advanced and secure electronic communication; (3) personalizing care with consumer-based health records and better information for consumers; and (4) improving public health through advances biosurveillance methods and streamlined collection of data for quality measurement and research.

Phase I focuses on the development of market institutions to stabilize the market, create a better environment for investment and accountability, and lower the risk of health IT procurement. Phase II involves investment in clinical management tools and capabilities such as personal health records and health information exchange, and phase III supports the transition of the market to performance accountability, where clinicians have the tools to manage patients and to deliver high quality care in an efficient manner.

HHS is currently implementing phase I. Phase I strategies include reducing the risk of electronic health record investment; fostering regional collaborations; developing a national health information network; coordinating federal health information systems; and encouraging the use of personal health records. HHS, however, has not established milestones for the completion of phase I, nor has it defined or made plans for phases II and III. Without defined milestones, it remains unclear when the important activities of phase I will be completed and when the building blocks to support activities of the subsequent phases will be available.

Lessons from other agencies and countries. The framework for strategic action includes plans to identify and learn from other agencies' experiences, including those of the Departments of Defense (DoD) and Veterans Affairs (VA), which operate the largest health care delivery networks in the country and have experience with developing and implementing IT solutions throughout their systems. Other countries, including Canada, Denmark, and New Zealand, also have begun to develop strategies to improve health care delivery through the nationwide adoption of IT. According to the GAO, these sources provide valuable lessons for HHS.

DoD and the VA reported the need to: (1) obtain full endorsement of top leadership, (2) define and adopt common standards and terminology, (3) recognize and address the needs of the varied stakeholder communities, and (4) deploy in small increments and build on success. Canada, Den-

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mark, and New Zealand identified the following lessons learned from their experiences: (1) focus on creating standards first, (2) establish a central organization to lead health IT efforts, and (3) implement solutions incrementally.

GAO recommendations. To accelerate the adoption of interoperable IT for health care, GAO recommends that the Secretary of HHS establish and follow detailed plans and set milestones for each phase of HHS' framework for strategic action. HHS agreed with GAO's recommendation and described additional actions that the Secretary is taking to achieve specific goals of the framework, including reallocating funds and holding roundtable discussions with stakeholders. ■

GAO Report, GAO-05-628, May 2005, ¶550,066

State statute prohibiting use of state funds preempted by NLRA

by Sheila Lynch-Afryl, J.D., Contributing Editor

A state statute that prohibited the use of state funds, including Medicaid funds, from encouraging or discouraging union organization was preempted by the National Labor Relations Act (NLRA) because it interfered with the open advocacy by both employers and employees that must exist for the NLRA collective bargaining process to succeed. A group of five health care organizations sought to overturn this state labor law statute on the grounds that it was unconstitutional and that the NLRA preempted the statute.

The state contended that the market participant exception to NLRA preemption applied because, through the Medicaid program, it acted as a market participant by buying services for low-income consumers much as an insurer or an employer providing benefits might buy health services. The market participant exception to NLRA preemption did not apply because the scope of the statute was not sufficiently narrow to encourage a general policy. Rather, it was designed to have a broad social impact in the overall labor market by altering the ability of a wide range of recipients of state money to advocate about social issues.

"The framework for strategic action includes plans to identify and learn from other agencies' experiences, including those of the Departments of Defense (DoD) and Veterans Affairs (VA), which operate the largest health care delivery networks in the country and have experience with developing and implementing IT solutions throughout their systems."

The section was preempted because its prohibition of encouraging or discouraging union organization interfered directly with the NLRA's own system for the promotion or deterrence of union organizing by employers or employees by allowing the state attorney general to impose monetary penalties and apply for orders enjoining the commission of a violation of the section. In addition, despite the proprietary language of the statute and its legislative purpose, the section did not essentially reflect the state's own interest in its efficient procurement of needed goods and services. While the organizations argued that the Labor Management Reporting and Disclosure Act also preempted the statute and that it posed constitutional challenges, the ruling as to NLRA preemption rendered these arguments moot. ■

Healthcare Association of New York State, Inc. v. Pataki, U.S. District Court for the Northern District of New York, No. 1:03-CV-0413, May 17, 2005 ¶14,901

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Valuing charitable care

by CCH Editorial Staff

Exempt organizations, especially those in the health-care industry, have recently been subject to increased scrutiny by the Internal Revenue Service (IRS). In some cases, hospitals are losing their exemption because they are using too much of their facility for nonexempt purposes, are providing little charity care, or are using abusive collection practices.

Charity care

Some tax-exempt hospitals that are the subject of IRS scrutiny are in the process of reviewing the value of their tax-exempt status and the value of the community benefit they provide, including charity care that they deliver, as part of their defense.

To value community benefits, it is "important to include as many benefits as possible," noted Thomas Neubig, Ernst & Young, Washington, D.C. "You're going to be compared to how much you are doing in the community benefit area above and beyond what for-profit hospitals are doing."

He said community benefit should include the value of outreach programs, education and screenings, research, scholarships, and charity care. This care includes direct care provided to uninsured or underinsured patients, unprofitable services or facilities that are part of the hospital's charitable mission, and bad debt write-offs in certain cases. In addition, economic and fiscal benefits provided by a hospital to the local community should be included. These benefits include increased local jobs, increased purchases from local suppliers and additional sales and property taxes.

A recent study by the Metropolitan Chicago Healthcare Council (MCHC) shows the impact of these economic benefits in a community. The MCHC study showed that Chicago-area hospitals generate $23.7 billion in personal income for residents, account for more than 400,000 primary and secondary jobs, and contribute $1.8 billion in capital improvements.

It is important to quantify and present the community benefit not just as a compliance measure, but to show the value of the hospital to the community, Neubig added.

An analysis of the value of tax-exempt status, Neubig said, targets four areas:

(1) Federal tax liabilities;
(2) State and local tax liabilities;
(3) Tax liability on built-in gain of existing assets; and
(4) Non-tax costs, such as no longer being able to benefit from lower interest rates of tax-exempt bond financing, loss of fundraising dollars and volunteer labor, and higher postage costs.

The value of the tax-exemption cannot simply be added together-there are interactions and behavioral implications. "Calculate income taxes last; paying taxes such as property taxes may eliminate taxable income." "If a simplistic approach is used, it might greatly overstate the value of tax-exemption," Neubig remarked.

Reporting community benefit

Community benefit is reported on Form 990, *Return of Organization Exempt From Income Tax, Part III-Statement of Program Service Accomplishments.*. "In light of today's environment, this is the one place on an annual basis that you have to toot your own horn," advised Donna Borgese, Senior Manager Corporate Taxation, UPMC Health Systems, Pittsburgh. "One of the biggest ways to do this is through [community benefit] measurements."

She said that the public also uses information in the Form 990 for other purposes, such as to challenge the amount of charity care an entity provides. More detailed community benefit information may lead to fewer challenges and government scrutiny. Borgese added that an organization "needs to value [community service data] in an auditable manner."

In addition, make sure Form 990 information is consistent with other information provided to the public, said Cara Breidster, Ernst & Young, Indianapolis. She suggested running the community benefit information past the organization's CEO and the marketing group. ■

CCH Chicago Bureau, May 26, 2005

Criteria for granting hospitals tax-exempt status examined

by Catherine Hubbard, M.A., Contributing Editor

The current criteria for providing tax-exempt status to nonprofit hospitals is unclear, outdated and should be reviewed, according to House Ways and Means Committee Chairman Bill Thomas, R-Calif. "What do we get for our money?," he asked at a May 26 hearing.

Thomas is holding a series of hearings on the nonprofit sector, but he is paying particular attention to tax-exempt hospitals. He cited statistics showing that health-related organizations make up 60 percent of total revenues from Code Sec. 501(c)(3) non-profits. And of the various types of health care organizations, hospitals constitute almost three-quarters of total revenues, he noted.

Ranking member Charles Rangel, D-N.Y., said the tax code should be overhauled to address all nonprofit sectors and tax subsidies."Why are you picking on hospitals?" he asked. Many types of institutions do not pay taxes, he said, adding that "There is no evidence of wrongdoing" at nonprofit hospitals.

"We haven't singled them out," said Everson, adding that the Internal Revenue Service (IRS) is examining up to 20 non-profit sectors, including credit counseling, education, conservation easements and Indian gaming.

Yet, Thomas stated that in the health care indstry in particular, "We really can't tell the difference between a for-profit and a not-for-profit." To support his position, Thomas cited data from the American Hospital Association that claims that uncompensated care is nearly equal between nonprofits and for-profits, both at about 4.5 percent of care provided. Given the size of the federal tax subsidies, estimated in the 10s of billions of dollars, and the competitive advantages nonprofits have, Thomas said, the government should make sure "taxpayers are getting at least some commensurate benefit for the tax-exemption amount."

IRS Commissioner Mark Everson, said the IRS welcomes a "thorough review" of the sector. "We at the IRS are now faced with a health care industry in which it is increasingly difficult to differentiate for-profit from non-profit health care providers," he said. "We have made the tax-exempt sector a service wide priority," he added.

"[The current comptroller general of the Government Accountability Office] stated that current tax policy lacks the specific criteria with respect to tax-exemptions for charitable entities and called on Congress to examine which entities receive the subsidies, why they receive the subsidies and the public benefit achieved for the tax dollar."

The current "community benefit standard" for exemption of a hospital, set forth in Revenue Ruling 69-545, is based on such standards as whether the facility provides emergency care, provides uncompensated care, and has an independent board.

David Walker, comptroller general of the Government Accountability Office, said there is no clear distinction between the community benefit provided by for-profits and nonprofits. "We were not able to discern a clear distinction among the government, nonprofit, and for-profit hospital groups," he said.

He added that current tax policy lacks specific criteria with respect to tax-exemptions for charitable entities, and called on Congress to examine who receives the subsidies, why they receive the subsidies and the public benefit achieved for the tax dollar.

Still, Walker cautioned against removing tax-exemptions broadly or too soon. "We need more solid data in order to be able to make informed decisions," he stated. ■

CCH Chicago Bureau, May 26, 2005

IRS seeks to speed application process for tax-exempt status

by CCH Editorial Staff

The Internal Revenue Service (IRS) has begun processing approximately 45,000 applications for tax-exempt status thus far in fiscal year 2005, the IRS's Janet Gitterman reported. While some of those applications are holdovers from the prior fiscal year, many are applications on the newly revised Form 1023, *Application for Recognition of Exemption Under Section 501(c)(3) of the Internal Revenue Code.*

Form changes. Form 1023 was recently overhauled by the IRS. Gitterman said that she hopes "it is a pleasant change from the old one." As of May 1, the IRS no longer accepts the old Form 1023.

Gitterman explained that the new Form 1023 and the accompanying instructions were designed for ease of use. From the outset, the IRS focused on using as much plain English as possible. The IRS also added a glossary of terms to the instructions to assist in completing the form.

IRS scrutiny. IRS Commissioner Mark W. Everson stressed that deterring abuse within the tax-exempt area is a major priority of the IRS. He commented that "the vast majority [of charities] are law-abiding, but we cannot let a few bad apples taint one of the pillars of our society." He called on the tax-exempt community to police itself for its own sake. "I am hopeful that the tax-exempt community gets it. Unless you root out problems," Everson said, "it will hurt the entire community."

The Commissioner lamented the fact that the "twin cancers" of technical abuse and outright abuse have migrated into

the tax-exempt community. He attributed the rise in abuse to a number of factors, including the regulatory challenges that come with a large and complex sector, the decline in IRS resources, the lax compliance attitude, attorneys and accountants and the rise of terrorism.

Among the 20 areas of ongoing abuse that have been identified, the IRS is intensely scrutinizing donor-advised funds, supporting organizations, charitable donations, appraisals, excessive compensation and the credit counseling industry.

"Among the 20 areas of ongoing abuse that have been identified, the IRS is intensely scrutinizing donor-advised funds, supporting organizations, charitable donations, appraisals, excessive compensation and the credit counseling industry."

EO division heats up. "It is an exciting time to be in Exempt Organizations," remarked Martha Sullivan, EO Division Director. Sullivan added that it has been a busy time for the EO Division as the need for enforcement within the tax-exempt community has grown.

The division has formulated a number of programs to curb abuses. It is currently leveraging resources by working with state taxation authorities. A number of pilot programs have been developed with states to help uncover abusive organizations. As a result, the EO Division has found many organizations that were required to file Forms 990 but failed to do so.

The EO Division has also created Data Analysis Units that examine statistical changes among filings by tax-exempt organizations. The DAUs are designed to predict where new issues will arise. "We need to analyze where compliance problems lie. Now we are better able to handle these issues," commented Sullivan.

The EO compliance unit has also sent out nearly 18,000 compliance check letters and educational letters to exempt organizations. Correspondence audits allow the division to "touch" more tax-exempt organizations than other audit methods.

In addition, the division is working to resolve problems such as abuses of charitable easements, contributions of inventory and donations of intellectual property, commented Sullivan. ■

CCH Chicago Bureau, May 26, 2005

IRS official, practitioner discuss EO audits

CCH Editorial Staff

The focus of the Internal Revenue Service (IRS) in the tax-exempt area has shifted from customer service to enforcement, according to Betty McClernan of the IRS Exempt Organizations (EO) Division. McClernan, speaking to members of the Washington, D.C., Bar Association, pointed out some trends that she has noticed in her division over the past ten years. Among them are that the number of applications and returns has increased by a third, with a large increase of organizations in the IRS MasterFile, while staffing has been reduced. As a result, audit coverage has slipped from about one percent to approximately four-tenths of one percent.

IRS updates process. The IRS intends to handle applications for tax-exempt status within 100 days, but the current average is 112 days, and the typical cycle time for examinations (from the organization's first contact with an agent) is 236 days, McClernan indicated. Noting that the IRS is still concerned about customer service, she reminded attendees about the customer satisfaction surveys, particularly the comments section, telling them that the IRS wants responses and looks at the comments.

McClernan indicated that attention has been focused on the Exempt Organizations Division, drawing specific mention from IRS Commissioner Mark Everson, which was unusual for that unit. The IRS has done some significant hiring in this area, which will pay off eventually but means that experienced agents have been taken offline to assist with training,

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thus slowing response times. Much of the new staff will be assigned to compliance checks and correspondence audits.

Practice tips. Even though the IRS has issued a new application for qualification as an exempt organization, Form 1023, Application for Recognition of Exemption Under Section 501(c)(3) of the Internal Revenue Code, the IRS will still be checking all of the usual issues about whether the organization's exempt activities are still its main activities, said James Joseph, of Arnold & Porter, LLC.

Varying levels of requests for information and documents exist, from compliance checks up to on-site examinations. Joseph regarded the following as practices that would benefit attorneys in their representation of tax-exempt clients:

- Establish good relations with the examining officers;
- Help shape the course of the examination wherever possible;
- Manage the flow of information to the IRS officials;
- Make certain you are aware of the content that the examiners are receiving;
- Prevent uncoordinated statements to the IRS. ■

CCH Washington Bureau, May 16, 2005

HHA's president assessed $673,000, excluded for 7 years for fraudulent claims

by Sheila Lynch-Afryl, J.D., Contributing Editor

A seven year period of exclusion, civil money penalties (CMPs) of $38,000, and an assessment of $673,212 were reasonable against a home health agency's (HHA) president and CEO, the Departmental Appeals Board (DAB) found. A one year period of exclusion, a CMP of $2500, and an assessment of $2146 were reasonable against the HHA's director of finance. Both individuals submitted cost reports for claims for medical or other items or services that they knew or should have known were not provided as claimed or were false or fraudulent, found the Departmental Appeals Board (DAB).

Liability of the HHA's president. The HHA's president submitted claims for 178 items or services for fiscal years 1995 through 1997, including: (1) professional fees for business valuation and expert witness testimony related to his divorce; (2) marketing program fees to increase patient utilization of the HHA's services; (3) advertising fees for a flu shot program; (4) costs related to the personal use of luxury vehicles; (5) charitable donations; (6) social club dues; (7) costs for pest control services at the president's private residence; and (8) valuation expenses related to the sale of the HHA. The DAB determined that the president had direct knowledge that these fees were not allowable costs reimbursable through the Medicare and Medicaid programs and acted with reckless disregard of this knowledge when he included such costs in his 1995-1997 cost reports.

The president also ignored certification statements and intercepted the mail to conceal invoices. The number, nature, and duration of the submissions or improper claims established a pattern of willfully ignoring reimbursement requirements to maximize his own reimbursement.

Liability of the HHA's director of finance. According to the DAB, the director of finance filed claims for automobile expenses, social club dues, charitable donations, and fees relating to business valuation expenses, which she knew or should have known were unallowable expenses. The Inspector General's (IG) suggested penalty of exclusion for five years, a $20,000 CMP, and an assessment of $100,000 was improper, however, because the IG failed to prove that the director had actual, concrete knowledge that most of the claims were improper, nor did the IG show a motive that could be traced to greed.

Corporate successor's settlement with the IG. After the fraudulent cost reports were filed, the HHA was sold and the successor entered into a settlement with the IG for $125,000. Although the DAB found that the settlement did not release the president and director from liability, because their liability was based on their own individual conduct, the settlement amount was divided pro rata to reduce the president's and director's assessments.

Application of BBA. The Balanced Budget Act of 1997 (BBA) PubLNo 105-33) amended the Social Security Act to clarify that reasonable costs did not include costs for entertainment, donations, or personal use of vehicles. The president and director of finance claimed that this statutory amendment was applied retroactively to acts that occurred before the amendment. The DAB, however, held that the section merely codified existing policy regarding the three cost categories, and therefore, did not invalidate any vested rights or interfere with any settled expectations that guided the president's and director's conduct. ■

The Inspector General v. Horras, Departmental Appeals Board, Civil Remedies Division, Decision No. CR1300, April 29, 2005, ¶300,110

CMS officer agrees to license suspension for falsifying CME records

by Catherine Hubbard, M.A., Contributing Editor

CMS Chief Clinical Officer (CCO) and director of the Office of Clinical Standards and Quality, Sean Tunis, has agreed to a one-year suspension from practicing medicine for falsifying documents related to the completion of continuing medical education (CME) courses. Practicing physicians are required to complete CME courses to keep their licenses. A CMS spokesperson on June 8 said Tunis is on administrative leave, but had no comment on the case. The acting CCO and director of the Office of Clinical Standards and Quality is Barry Straube.

The Maryland Board of Physicians (Board) in April charged Tunis with falsifying the documents. According to the Board, Tunis agreed to a suspension for a minimum of one year. The Board found the physician guilty of unprofessional conduct in the practice of medicine, willfully making or filing a false report in the practice of medicine, and willfully making a false representation when seeking or making application for licensure in regard to submission of CME certificates for hospital reappointments and a licensure renewal application.

After the ruling, Tunis resigned from Mercy Medical Center in Maryland, where he had worked part-time, approximately a week per year, according to Dan Collins, director of media relations for Mercy. ■

CCH Washington Bureau, June 6, 2005

HIPAA Security Guide

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