CCH Health Care Compliance LETTER

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Medicaid portion of state budgets increasing, report finds

by Catherine Hubbard, M.A., Contributing Editor

Medicaid continues to constrict state budgets, according to a report issued by the National Governors Association (NGA) and the National Association of State Budget Officers (NASBO) in June 2007. The report, entitled "The Fiscal Survey of States," revealed that the Medicaid program represents 22 percent of total state spending. Meanwhile, all health care accounts for about 32 percent, the single largest portion of total state spending, the associations said.

Over the past year, health insurance issues have become increasingly significant at the state level, NGA and NASBO said in their report. Thirty-four governors introduced plans to reduce the number of uninsured residents in their states in fiscal year (FY) 2008. Those plans rely on a variety of vehicles, including expansion of the State Children's Health Insurance Program, traditional Medicaid expansion, using flexibilities offered under the Deficit Reduction Act, waivers, and various state programs. Proposed FY 2008 funding for these programs totals nearly $18.4 billion, according to the report.

While the national uninsured rate is about 16 percent, individual state percentages range from about nine to 25 percent of the state's population. Most states plan to reduce the number of uninsured residents by using Medicaid as a building block for additional coverage and financing, NGA and NASBO said. While Medicaid spending rates have moderated somewhat, Medicaid spending is estimated to increase by 5.8 percent in governors' recommended budgets for FY 2008, with state funds increasing by 7 percent and federal funds increasing by 4.9 percent, according to the report.

In FY 2007, total Medicaid spending is estimated to increase by 6.6 percent, with state funds increasing by 8 percent and federal funds by 6.1 percent. Since Medicaid makes up such a large portion of state budgets, these large growth rates have a significant impact on states, NGA and NASBO noted.

In fiscal 2006, the Medicaid spending growth rate of 2.5 percent was significantly lower than previous years due in part to the inclusion of dual eligibles in the Medicare Part D program. Other costs for the dual eligibles, such as for long-term care, remain within the Medicaid program.

About two-thirds of governors have included plans to expand health care coverage in proposed FY 2008 budgets. Proposals vary widely from aiming to cover all of the state's uninsured residents to targeted expansions for specific groups such as uninsured children. The associations noted that the approximate number of additional people that would be covered under governors’ proposals ranges from 268 to 4.8 million.■

CCH Washington Bureau, June 13, 2007.

MDs to limit services if Medicare payment rates are cut

by Catherine Hubbard, M.A., Contributing Editor

The forthcoming 10 percent physician payment cut, scheduled for January 1, 2008, will force 60 percent of physicians to limit the number of new Medicare patients they will be able to treat next year, the American Medical Association (AMA) predicted at a June 4, 2007, briefing in Washington, D.C.

The AMA urged Congress to enact legislation to replace the cuts with Medicare payment updates. In addition, the Medicare Payment Advisory Committee has recommended that Congress increase payments by 1.7 percent, in line with practice cost increases, the AMA noted.

Survey results. For a period of over nine years, the cuts total about 40 percent, while the government estimates the cost of caring for patients will increase 20 percent. Over the life of the cuts, 77 percent of physicians will be forced to limit the number of new Medicare patients they treat, the AMA said. Last year's cut was avoided due to last minute congressional action.

According to the survey:

- more than two-thirds of physicians will defer purchases of information technology next year;
- over the life of the cuts, about eight in 10 physicians report they will have to forgo purchases used to improve health care quality;
- more than half of physicians say they will reduce their practice staff; and
- 14 percent will get out of patient care when Medicare cuts hit next year.

Recommendations. The AMA recommended that instead of the physician cuts, Congress eliminate extra payments to Medicare Advantage plans. "It's shameful that under current law Medicare will slash payments to doctors well below the cost of caring for seniors, while increasing payments to highly profitable managed care companies," said AMA Board Chairman Cecil Wilson. "Congress has to make a choice – preserve access to care for all seniors by stopping next year's Medicare cut to doctors, or continue to help insurance companies line investors' pockets," Wilson said in a statement to the House Ways and Means Subcommittee on Health in May.

CCH Washington Bureau, June 5, 2007.

Spending growth caused by rising volume of physicians' services

by Catherine Hubbard, M.A. and Valerie L. Witmer, J.D., Contributing Editors

Recent growth in per-beneficiary Medicare expenditures for physicians' services can be explained by growth in the volume and intensity of services provided rather than by changes in Medicare's payment rates, according to a report issued by the Congressional Budget Office (CBO) in June 2007. CBO's analysis found an annual trend of four percent growth in the quantity of services provided by physicians from 1997-2005.

Decline in payment rates. CBO noted that Medicare's payment rates declined slightly from 1997-2005. The decline is attributable to sustainable growth rate (SGR)-related changes in the conversion factor, which translates the geographically-adjusted relative-value

units - which measure the resources required to perform a given service - into a dollar payment amount. These changes, aimed at controlling Medicare's outlays for physicians' services, offset other factors in Medicare's pricing system that otherwise would have led to higher payment rates.

Rising quantity of services. Despite efforts to control costs, Medicare's spending on physicians' services has continued to grow rapidly. According to CBO's analysis, "[c]hanges in the quantity of physicians' services alone would have increased spending by 39.4 percent." A 4.9 percent reduction in payment rates offsets a portion of that increase, resulting in a net increase in spending of 34.5 percent.

Of the 39.4 percent increase in the quantity of physicians' services, CBO found that "most of the increase [was] attributable to the underlying trend in the quantity of services rather than the result of behavioral responses to changes in payment rates." Specifically, only 1.4 percent of the 39.4 percent quantity increase were attributable to physicians and beneficiaries' responses to changes in Medicare payment rates, while 38.8 percent stemmed from coverage expansions, changes in the beneficiary population, prevalence of disease, and innovations in medical practice. ■

CBO Background Paper, June 2007.

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Susan Smith, J.D., M.A.
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Health Law–Catherine Hubbard, M.A.
Tax–Jeff Carlson, Steve Cooper

Designer
Don Torres

Requests for information about article submission and comments from readers are welcome and should be directed to Susan Smith at susan.smith@wolterskluwer.com, Tel. 847-267-2780, Fax 847-267-2514. Customer service inquiries should be directed to 800-449-9525.

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Revised Form 990 may ease filing burden

by John Scorza, Contributing Editor

The Internal Revenue Service (IRS) hopes that a revised Form 990, released on June 14, 2007, will be more relevant to modern charitable organizations and easier to understand. Form 990 is the annual information return filed by all exempt organizations, including hospitals, and has not been updated since 1979. Lois Lerner, director of the IRS's Exempt Organizations (EO) Office, stated that the existing form is illogical, inconsistent, and difficult to fill out. She indicated that the agency's goal was to have exempt organizations start to use the form by the 2008 tax year.

Suzanne McDowell, an exempt organizations practitioner at Steptoe & Johnson, Washington, D.C., pointed out that the information on compensation was not useful for today's organizations, in which bonuses, deferred compensation, and incentive compensation are included in compensation packages. McDowell said the new form takes an approach similar to Form 1040, whereby an individual fills out a basic form and the applicable schedules. The old Form 990 "looked overwhelming," McDowell commented.

Senate Finance Committee Chairman Max Baucus (D-Mont.), said the "new form will help the public and the IRS assess whether tax exempt organizations are staying true to the reasons they were granted exempt status in the first place." Ranking Republican Charles Grassley (R-Iowa), said taxpayers "deserve accountability for the generous tax breaks the federal government offers to tax-exempt groups. The IRS' revisions are on the right track." Grassley said the agency should get the final form in place as soon as possible. He criticized the draft form for proposing a disclosure threshold for salaries over $100,000, saying the threshold was too high.

Revision of the form was guided by three principles: enhancing transparency to provide a picture of the organization and a basis for comparison; promoting compliance by reflecting the organization's operations; and minimizing burden on filers.

Revisions. The new form consists of a one-page summary, a nine-page core form for all groups, and 15 schedules. Lerner estimated that only 20 percent of charitable organizations would need to fill out more than three of the schedules.

Other new schedules address foreign activities (Schedule F), hospitals (Schedule H), tax-exempt bonds (Schedule K), and noncash contributions (Schedule M).

The summary page is a "snapshot" that lists percentages for revenues and expenses, as well as amounts, and identifies the source of the information, McDowell said. The form is an attempt to put key information on the first page. It is useful, McDowell noted, because many people will go no further than the first page in their review of an organization's activities.

The revised Form 990 will look at board structure, whistleblowers, compensation paid through related organizations, fund-raising, financial statements, and taxes owed by the organization, such as employment taxes, excise taxes, or unrelated business income tax.

Corporate governance. The revised form asks about governance even though there are no governance requirements in the tax code. According to McDowell, many of these questions are drawn from the Sarbanes-Oxley Act. She questioned whether some organizations may adopt governance principles so they can answer yes on the Form 990 without really following them. The governance questions apply to all exempt organizations, including membership organizations like trade associations or labor unions that are more accountable to their members than to the public.

Lerner said the form is still a work in progress. EO is not done with the form and would like comments on both large and small features of the form. Comments are due by September 14, 2007. ■

CCH Washington Bureau, June 14, 2007.

IRS directive on EHR subsidies raises questions

by Brant Goldwyn, Contributing Editor

The Internal Revenue Service's (IRS') recent directive on electronic health record (EHR) subsidies continues to raise questions. During a June 14, 2007, teleconference sponsored by the American Health Lawyers Association, an IRS official clarified that if in the course of a field

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On The Front Lines

Looking at executive compensation in nonprofit health care organizations from a compliance-perspective, Part I

by Albert Y. Lin, Esq., Contributing Editor

To assist the compliance officer in understanding all of the issues impacting executive compensation in nonprofit health care organizations, this article provides a succinct, yet comprehensive, overview of the legal and practical considerations in evaluating the nonprofit health care organization's executive compensation package. Part 1 of this three part article discusses the legal meaning of executive compensation as it relates to health care organizations, which includes the compensation of medical staff physicians, who may not be "executives" in the common sense meaning, but nevertheless constitute a significant portion of payroll. Part I also begins a discussion on the legal framework for analysis of executive compensation in the context of nonprofit organizations, which will continue through Part II. Part III concludes the article by offering compliance suggestions for the nonprofit board.

"More and more, we're seeing that some people view charities and charitable gifts as a chance to help themselves, not others." - Charles Grassley (R-Iowa).

The current governmental and media scrutiny of nonprofit organizations and the compensation paid to their executives should concern compliance officers of health care organizations. Without true shareholders and partners, nonprofit organizations are conceptually accountable only to the public and, traditionally, have been treated with kid gloves. During the last four years, however, the public microscope has redirected its scrutiny to public charities after Sarbanes-Oxley provided some much-needed accountability in the for-profit sector. Attention is particularly attenuated in the health care sector where more than 80 percent of hospitals are nonprofit.

Nonprofit organization investigations come from both federal and state authorities. In the first quarter of 2007, the Internal Revenue Service (IRS) issued several results from various surveys and questionnaires delivered to organizations over the past few years with the likely consequence of tighter federal standards that must be met in not only obtaining but also maintaining tax exemption. Politically ambitious state attorney generals and property tax authorities force compliance with the local rules that enable hospital systems to save hundreds of thousands of dollars in local sales and property taxes. The media is quick to publicize defeats, and the cost of improper management must be measured not only by dollars lost through penalties and restitution, but the embarrassment of those found involved and held accountable.

I. What is Included in executive compensation?

The term "executive compensation" is never explicitly defined but for purposes of compliance reporting, it is clear the definition is very broad. With respect to the term "*executive*," the IRS has developed and is refining rules relating to compensation for not only the expected officers, directors, and key employees of the health care organization, but also *medical staff physicians* (whether employee or contractor) providing services, even if the physicians are not officers or directors. Thus, the focus on executive compensation may extend to physician compensation, particularly highly visible employee physicians.

The term "*compensation*" for purposes of compliance reporting should encompass base salary, incentive compensation (such as discretionary, performance-based, and fixed or lockstep bonuses), retirement benefits (including the tax-qualified 401(k)s, 403(b)s, 401(a)s, as well as the section 457(f) or "nonqualified" deferred compensation plans), recruitment incentives, health insurance benefits and medical disability benefits. The IRS also is quick to inquire about fringe benefits and perquisites such as country club dues, condominium use, charter transportation, vacations, business trips accompanied by spouses, and automobiles.

The compliance officer should be aware of the cost of the entire package of executive compensation within the system and should be prepared to show how the amounts were decided upon. With apologies to Hans Christian Andersen, the compliance officer's job is to find the exempt organization's "way home" by leaving the proverbial trail of bread crumbs in the form of documented analysis and minutes in arriving at the total executive compensation paid to officers, directors,

and physicians. The following discussion describes the layout of the navigable woods.

II. Legal framework for analysis of nonprofit compensation

1. *Know applicable state nonprofit corporation statutes & administrative guidelines*

With so much concern focused on IRS rules and regulations, nonprofit health care organizations seem to forget at times that the *state* nonprofit statute is the first "line of defense" against excessive executive compensation. Herein lies one useful clarification - the term "*nonprofit*" refers to a not-for-profit corporation or association established pursuant to *state* statutes. The term "*tax-exempt*" refers to the exemption from federal or state tax, which is granted not by the state Division of Corporations or Secretary of State (as with the nonprofit charter), but by the *IRS* or *state* taxing authority. In the health care sector, not all nonprofit organizations apply for or qualify as tax-exempt.[2]

The applicable state statutes are always worth reviewing, particularly because some small health care organizations (such as small indigent care clinics), as mentioned above, are created as nonprofit corporations under state statutes, but elect to forego federal tax exemption and file the for-profit federal tax return, IRS Form 1120.[3] The nonprofit charter (or articles of incorporation or certificate of formation) may outline the minimum requirements, and often contains a provision that only "reasonable" compensation pay be paid. State statutes will vary, but most states follow the Revised Nonprofit Corporation Act ("Act"), originally adopted by the American Bar Association in 1987. A revision to the Act is currently underway.

Key principles in the Revised Nonprofit Corporation Act, likely common in many states, include:

- a prohibition against distribution of net earnings (in the form of dividends or other payments representing distribution of profits) (§13.01 of the Act);
- statutory notification of the state attorney general of a dissolution of the nonprofit corporation (§14.03 of the Act); and
- statutory conflict of interest provisions (§8.31 of the Act), which set forth that transactions may be voidable by the state if not for fair value.

Additional concepts present in state statutes that are not in the model Act include:

- statutory duties of loyalty and care;
- requirements to submit financial statements to state authorities;
- revocation of charter in the event annual state reports are not filed with the applicable state authorities; and
- prohibitions or other limitations against loans to officers, directors, and employees.

Admittedly there is overlap between state nonprofit concepts and IRS rules, and the state and federal authorities work together in enforcement proceedings. Some jurisdictions require a copy of the federal IRS Form 990 (Annual Information Return for Exempt Organization) to be filed with the state department of revenue.

Some states have additional compliance responsibilities and have taken affirmative steps to recommend tighter compliance requirements, including New York, Illinois, Georgia, Iowa, Louisiana, Maryland, Minnesota, North Carolina, Ohio, Pennsylvania, and Utah. Maryland, for example, has published a code of conduct for nonprofits and has implemented a "*Voluntary Certification Program*" whereby nonprofits can demonstrate they comply with the suggested code and use a "*Seal of Excellence*" in solicitation materials. North Carolina, Ohio and Pennsylvania have licensed the code of conduct and certification program from Maryland. Other states have less formal, but still helpful, nonprofit "pledges" and "policies" that nonprofit hospitals might review and incorporate within their governance documents. Illinois has published its "Illinois Nonprofit Principles and Practices."

National industry associations such as the American Hospital Association and National Health Council[4] have suggested voluntary codes of ethics and governing principles that the health care compliance officer should review and coordinate with any state guidelines.

States may get even more aggressive. In late March of 2007, Rep. Cary Allred of the North Carolina House of Representatives introduced H.B. 1236, which actually proposes to limit the executive compensation of certain nonprofit health care organizations by subjecting compensation to the state commissioner of health and human services.[5]

Those responsible for evaluating and determining executive compensation in the nonprofit health care organizations should be mindful of these state parameters, even though the IRS rules are being modified at a relatively quicker pace. As stated above, some state nonprofit health organizations forego federal tax exemption in part to avoid the rigid federal rules - but must not forget the state limitations that still apply.

2. *Understand state common law fiduciary duties*

Litigation against officers and directors of nonprofits has resulted in years of case law outlining the duties that such leaders owe to the nonprofit organization and that supplement statutory law. In evaluating executive compensation, a key factor in performance should be whether or not the officer or director is fulfilling the duties that courts have found that are owed to the nonprofit organization and the community it serves.

- *The Duty of Care.* This duty requires that a director be informed of all relevant and reasonably available information (through attendance at meetings, consulting with experts, and review of all materials); and then act in good faith, with the care that an ordinary and prudent person in a like situation would reasonably believe appropriate under similar circumstances.

On The Front Lines (cont.)

- *The Duty of Loyalty*. The key duty implicated in executive compensation enforcement problems, this duty requires that a director subordinate his or her personal interests and make decisions that are in the best interests of the nonprofit corporation. Defense to the allegation of a duty of loyalty breach is the presence and adherence to a conflicts of interest policy in connection with the disputed transaction or compensation decision as well as the reasonableness of the compensation in questions.
- *The Duty of Obedience*. Unique to nonprofit corporations, this duty requires a director to be faithful to the purpose and goals of a nonprofit corporation. In evaluating compensation, the compensation committee should measure performance against the stated mission statement of the organization.

Litigation against executives focuses on the breach of the duty of loyalty when excessive executive compensation is paid - the best defense against such attacks will be documentation that the duties above are being fulfilled.

Part II of this article will continue the discussion on the legal framework for analysis of nonprofit compensation and will outline federal tax law concepts relevant to tax-exempt organizations such as private inurement and the deferred compensation rules. Part II also will discuss in detail physician compensation arrangements. Part III will conclude the article with compliance suggestions for the nonprofit board. ■

Albert Y. Lin, JD, LLM, is a partner at the Austin office of Brown McCarroll, L.L.P., where he practices in the firm's corporate/tax, and health care groups. A certified public accountant prior to attending law school, he serves on the Advisory Board of the CCH Health Care Compliance Letter and was a co-author, along with Frank Sheeder of Jones Day, of various chapters in the CCH Corporate Governance Guide.

[1] *See* Albert B. Crenshaw, *"Tax Abuse Rampant in Nonprofits, IRS Says,"* Washington Post (Apr. 5, 2005); available at *http://www.washingtonpost.com/wp-dyn/articles/A26388-2005Apr4.html*.

[2] In addition, nonprofit organizations may apply for tax-exempt status under varying Code sections such as § 501(c)(3) ("charitable" organizations") or 501(c)(4) ("social welfare" organizations).

[3] The reasons for foregoing tax-exemption are few, but generally some organizations prefer not to subject themselves to the more difficult, and admittedly tedious, IRS exemption process when the expenses of the organization will consistently meet or exceed its revenues. In these cases, compliance officers - or officers and directors, as it is doubtful such organizations have compliance officers - must be particularly cognizant of nonprofit statutes.

[4] *See http://www.nationalhealthcouncil.org/aboutus/stand-good_operating.htm*. The American Hospital Association's (AHA's) publication is not currently online but may be requested from the AHA at http://www.aha.org.

[5] H.B. 1236, N.C. Gen. Assembly Sess. 2007 (Mar. 29, 2007), entitled "An Act to Limit Excessive Compensation of Executives of Certain Nonprofit Corporations Providing Hospital and Medical Service Plans." The preamble to this proposed bill refers to bonuses that are "perceived as shockingly high" and contribute to "spiraling health insurance premiums."

Tax-Exempt Organizations (cont.)

examination an IRS agent finds private benefit or inurement outside the context of an electronic health record (EHR), the agent could look into the benefits related to the donation of health information technology (IT) as well.

IRS directive. In May, the IRS released a directive explaining that they will not treat the IT benefits that a hospital provides to its medical staff physicians as impermissible private benefit or inurement in violation of Internal Revenue Code (IRC) § 501(c)(3) if the benefit falls within the range of health IT items and services allowed by HHS' EHR regulations, and the hospital operates in accordance with the conditions set forth in the IRS directive. Lois Lerner, IRS Director, Exempt Organizations, indicated in May 2007 that "taxable hospitals are already doing this." She added, "[T]ax-exempt hospitals were concerned that there may be a concern from our end with regard [to these benefits] and exemption."

EHR arrangements are not like writing a check to doctors, Linda Moroney, an attorney with Drinker, Biddle, Gardner, Carton in Milwaukee, Wisconsin, commented during the teleconference. According to Moroney, physicians using an EHR arrangement do not walk away with anything at the end of the day; they merely have something they can access at the time the service is provided to the hospital. Therefore, there is no accretion to wealth under IRC § 61. Alternatively, EHR subsidies may qualify as a fringe benefit not taxable to participating physicians under IRC § 132, Moroney indicated.

Shared access. Participants in the teleconference also addressed the extent to which physicians must provide the hospital with access to their patients' EHRs. According to the IRS, hospitals should have some level of access to patient records. An EHR arrangement that is subsidized for the benefit of participating physicians, but gives the hospital no access, could constitute an impermissible private benefit or inurement in violation of § 501(c)(3).

Cost sharing. Participants also addressed cost-sharing issues raised by the IRS' directive. According to the IRS, physicians would need to pay their share of costs for an EHR arrangement prior to receiving the benefit. Otherwise, this may be viewed as reimbursement for expenses and monetary remuneration. However, the IRS stipulated that the directive allows hospitals to vary the allocation of costs between the hospital and participating physicians. The directive mandates that, at a minimum, 15 percent of the costs be paid by physicians, but permits different allocations among different groups of physicians.

Possible limitations. According to Moroney, a hospital could limit the subsidy to a certain level of physicians, such as "active" medical staff. Marilyn Lamar, an attorney with Liss $ Lamar in Oak Brook, Illinois, noted that a hospital could provide the subsidy to a group practice that includes some physicians not on the hospital's medical staff without running afoul of the IRS' directive and HHS' regulations. Lamar indicated that it also may be possible to provide the EHR subsidy to physicians not on the hospital’s medical staff so long as the community rationale is followed. ■

CCH Washington Bureau, June 14, 2007.

OIG withdraws rules on excessive charges and discounted care

by Stacey Fahrner, J.D., M.P.H., Contributing Editor

Based on public comments to a proposed rule that would have provided further guidance on exclusion for excessive charges, the Office of Inspector General (OIG) has declined to promulgate a final rule because of the potential for unintended increases health care costs across the industry. The OIG also has declined to issue a final rule that would have clarified that free or substantially reduced charges to uninsured persons would not affect the calculation of a provider's or supplier's "usual" charges, as that term is used in the exclusion provision.

Excessive charges. Under 42 C.F.R. § 1001.701(a)(1), the OIG may exclude an individual or entity that has "[s]ubmitted, or caused to be submitted, bills or requests for payments under Medicare or any of the state health care programs containing charges or costs for items or services furnished that are substantially in excess of such individual's or entity's usual charges or costs for such items or services."

In the notice of proposed rulemaking, issued in September 2003, the OIG proposed to define the terms "usual charges" as either the provider's average charge or the provider's median charge, and "substantially in excess" as those charges or costs that are more than 120 percent of an individual's or entity's usual charges or costs.

Commenters were particularly concerned with the proposed 120 percent benchmark and stated that, to comply with the rule, providers that were charging Medicare and state health care programs in excess of the 120 percent benchmark could either lower charges to government programs or increase charges to other payors. The commenters were concerned that some providers would opt to raise their prices to other payors rather than lower their charges to Medicare and state

health care programs. This behavior, the commenters noted, could result in increased costs across the health care industry.

Based on the comments, the OIG concluded that there was insufficient information at this time to establish a single, fixed numerical benchmark for "substantially in excess" that could be applied equitably across health care sectors and across items and services, as originally proposed. Instead, the OIG said it will continue to evaluate individuals' and entities' billing patterns on a case-by-case basis.

Discounted care. The OIG has completed its review of the public comments to the proposed regulation clarifying treatment of discounted care and has concluded that it will not

promulgate a final rule. OIG stated that when calculating their "usual charges," individuals and entities do not need to consider free or substantially reduced charges to (i) uninsured patients or (ii) underinsured patients who are self-paying patients for the items or services furnished. The decision to forgo publishing a final regulation will not change the OIG

policy announced in the February 2, 2004 guidance entitled "Hospital Discounts to Patients Who Cannot Afford to Pay Their Hospital Bills." ■

Notice of Withdrawal of Proposed Rulemaking, 74 FR 33430, June 18, 2007.

HHS Release, June 18, 2007.

Complaint alleges physicians conspired to limit Medicaid services

Illinois Attorney General Lisa Madigan filed a lawsuit against two physician groups alleging they violated the Illinois Antitrust Act by illegally agreeing to stop accepting new Medicaid-eligible patients seeking primary medical care.

Madigan stated, "[M]edical clinics, like other businesses, must adhere to the antitrust laws. These laws prevent competitors, in all fields, from agreeing with each other to act collectively to limit access to services in order to raise prices."

Antitrust allegations. The complaint specifically alleges that physician groups agreed to boycott new Medicaid patients seeking primary medical care by adopting virtually identical policies through which they refused to accept Medicaid patients who (1) were not already registered with the clinic, or (2) had not seen a clinic physician for at least three years. In addition, the complaint alleges that the physician groups agreed to boycott Medicaid-eligible patients in an effort to increase the Medicaid reimbursement rates and accelerate reimbursement payments from the state.

According to Madigan, because the two physician groups employed more than 90 percent of the physicians in the affected county, Medicaid patients were denied access to primary care. As a result, some Medicaid patients were compelled to seek routine medical care at area hospital emergency rooms, causing the state to incur higher Medicaid reimbursement costs.

TThe complaint details several examples of the impact of the policy to refuse to provide primary medical care to new Medicaid patients:

- At the start of the 2003 school year, 285 children were not allowed to begin school because they could not get their required examinations and vaccinations before the October 15 deadline. Although many of these children were Medicaid-eligible, they could not get examined by a physician because the physician groups refused to see them.
- Many premature babies, once released from the hospital, have been refused continued medical care.

The complaint asks the court to enter an injunction requiring the physician groups to open their doors to new Medicaid patients. The complaint also seeks civil penalties and recovery of damages for the clinics' anticompetitive misconduct. ■

Illinois Attorney General Press Release, June 14, 2007.

Information Technology

Health IT coalition promotes new legislation

by Catherine Hubbard, M.A., Contributing Editor

A coalition to promote rapid deployment of health information technology (HIT), called Health IT Now!, has been formed by former Rep. Nancy Johnson (R-Connecticut) and former Sen. John Breaux (D-Louisiana). The coalition will push for federal legislation to promote a connected HIT system.

According to Johnson, former Chairman of the House Ways and Means Health Subcommittee, "&[T]here is broad consensus on a series of steps that Congress can take to eliminate barriers, establish guidelines and empower patients and the health care industry to take advantage of cutting-edge information technologies."

"Most industries have benefited from the widespread adoption of information technology. Health IT involves no more than implementing the kind of electronic information systems already used in many business sectors and putting it to work in health care," said Breaux, former member of the Senate Finance Committee.

The coalition believes federal legislation should include: (1) a permanent law establishing federal responsibility to lead a public-private process to establish standards for system interoperability, product certification, and quality measures, as well as an accelerated process for standards improvement; (2) federal financial incentives to providers to facilitate the adoption of HIT, and for communities, states, and other entities to plan HIT components and develop health information exchanges; (3) federal focus on consumer empowerment to encourage patient use of electronic health records and provider quality information; and (4) federal leadership of a federal-state process to resolve policy issues central to a secure and safe health care system.

According to the coalition, the implementation of health IT could save approximately $81 billion annually through the effective use of interoperable medical information systems, and the adoption of electronic medical records could reduce

In the News

Comparative effectiveness research for Medicare beneficiaries considered

Increasing research and information on comparative clinical effectiveness would help improve health care delivery and save Medicare dollars, according to lawmakers who addressed a panel of the House Ways and Means Health Subcommittee on June 12, 2007. Chairman Pete Stark (D-Calif.) said rising health care costs and a lack of clinical evidence have led many to call for a federal effort to substantially increase information on the relative effectiveness of health care services. Rep. Thomas Allen (D-Maine) has introduced the Enhanced Health Care Value for All Act (H.R. 2184), which would create a public-private funding mechanism to pool federal resources with funds from health insurance plans and large employers with self-insured plans.

CCH Washington Bureau, June 12, 2007.

Tighter controls on internet drug sales needed

The Senate Judiciary Committee is considering legislation that would create new tools for law enforcement to prosecute those who illegally sell drugs online, and allow state authorities to shut down online pharmacies before they get started. Lawmakers at a May 16, 2007, Senate Judiciary Committee hearing on rogue online pharmacies that illegally traffic in controlled substances called the issue a growing problem and one that warrants increased government intervention. The 2006 National Survey on Drug Use and Health indicates that almost 6 million people currently misuse prescription drugs and, of those, more than two-thirds -- 4.4 million people -- abuse pain relievers such as OxyContin.

CCH Washington Bureau, May 17, 2007.

Plans suspend PFFS marketing

CMS announced on June 15, 2007, that in response to concerns about marketing practices, seven health care sponsors have signed an agreement to suspend voluntarily the marketing of Private-Fee-For-Service (PFFS) plans. This suspension for a given plan will be lifted only when CMS certifies that the plan has the systems and management controls in place to meet all of the conditions specified in the 2008 Call Letter and the May 25, 2007, guidance issued by CMS. The signatories include: United Healthcare, Humana, Wellcare, Universal American Financial Corporation (Pyramid), Coventry, Sterling, and Blue Cross/Blue Shield of Tennessee.

CMS Press Release, June 15, 2007.

House committee approves IT training grants

The 10,000 Trained by 2010 Act (H.R. 1467), which authorizes the National Science Foundation to award grants to colleges and universities to research and support the education and training of health care informatics personnel through newly-established degree programs or multi-disciplinary Health and Medial Informatics Research Centers, was approved by the House Science and Technology Committee on May 23, 2007. According to the bill's sponsor, Subcommittee Chairman David Wu (D-Oregon), "A workforce capable of innovating, implementing and using electronic health systems will be critical to the successful transition. Education will be key to digitizing the health care industry."

Committee on Science and Technology Press Release, May 23, 2007.

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health spending by 7.5 to 30 percent. ■
CCH Washington Bureau, June 5, 2007.