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**By Albert Y. Lin, LL.M., CPA,
Advisory Board Member**

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CMS proposes changes to Medicare Part B payment policy

CMS has proposed changes to the Medicare Part B payment policy to ensure that payment systems are updated to reflect changes in medical practice and the relative value of services delivered by physicians to beneficiaries under the 2009 Medicare Physician Fee Schedule (MPFS). Under Medicare law, CMS is required to reduce 2009 Physician Fee Schedule by 5.4 percent.

Improvements in PQRI. The CMS proposed rule would provide for additional improvements to the Physician Quality Reporting Initiative (PQRI), including: (1) a final set of quality measures to be selected from 175 measures that fall into four broad categories; (2) increasing the number of conditions covered by measures groups to nine; (3) two new reporting periods to provide eligible professions with additional options for reporting PQRI data; and (4) accepting PQRI data via clinical registries and electronic health records systems.

Eligible professionals who are not currently participating in the PQRI will have the opportunity to begin reporting in July 2008. Eligible professionals who have reported PQRI data successfully for the full year can earn an incentive payment based on their total Medicare allowed charges for services furnished in 2008, while those who begin reporting in July can earn an incentive payment based on their total allowed charges from July 1 through December 31, 2008.

Diagnostic testing. CMS also is proposing to improve the quality of diagnostic testing performed by physicians and nonphysician practitioners in their offices by requiring them to enroll as suppliers of these services and to meet certain quality and performance standards, including applicable federal and state licensure and health and safety requirements that currently apply to independent diagnostic testing facilities. The standards would be effective January 1, 2009, for newly enrolling suppliers, but would allow existing suppliers until September 30, 2009, to comply.

Computer-generated faxes. CMS also would retain the provisions that allow for use of computer-generated faxes in instances of temporary/transient transmission failure or communication problems that preclude the use of the adopted NCPDP SCRIPT standard, and would add an exemption for computer-generated faxes used by dispensers to request refills from providers that are not capable of receiving and processing refill requests using the adopted NCPDP SCRIPT standard. ■

CMS Proposed Rule, 73 FR 38501, July 7, 2008.

Congress overrides President's veto of bill to halt physician pay cuts

On July 15, 2008, Congress overrode President Bush's veto of legislation that will stave off a 10.6 percent reduction in Medicare physician payments that was to take effect on July 1 and increase physician pay by 1.1 percent in 2009. In addition to physician payment changes, the "Medicare Improvements for Patients and Providers Act of 2008" (MIPAA) (H. 6331) will decrease payments to Medicare Advantage (MA) plans. The override vote was 70 to 26 in the Senate and 383 to 41 in the House. The Senate had passed the legislation with a veto-proof 69 to 30 after the House passed the bill with a veto-proof margin of 355 to 59.

After the Senate failed to pass the bill earlier this month, the Bush administration agreed to delay until July 15 paying physicians at the lower rate while lawmakers were home for the July 4 recess. The administration, however, made clear that it opposed reductions in MA payments included in the bill, saying they would "fundamentally change the private fee for service program and consequently reduce access, benefits, and choices for many of the approximately 2.25 million beneficiaries who have chosen to enroll in private fee-for-service plans, many of whom live in rural areas."

Physician payments. MIPAA blocks pending cuts scheduled under the sustainable growth rate payment formula through December 31, 2009; extends the 0.5 percent increase in the fee schedule conversion factor for 2009; and provides a 1.1 percent update in the conversion factor for 2009. It reapplies the budget neutrality adjustment for recent relative value unit (RVU) changes to the conversion factor, instead of the current work RVUs, effective January 1, 2009.

The Act also (1) extends an exceptions process for the therapy caps through 2009 and permits speech language pathologists in private practice to bill Medicare directly for their services rather than through a physician's office; (2) allows physicians in the armed services to engage in substitute billing arrangements for longer than 60

days when they are ordered to active duty; (3) restores a portion of cuts recently applied to psychotherapy and related services and phases out the Medicare copayment required for outpatient psychiatric services by 2014; and (4) increases payments for anesthesiologists involved in the training of physician residents in certain cases.

E-prescribing, physician incentives. MIPAA extends the physician quality reporting initiative (PQRI) through December 31, 2010, and increases the PQRI bonus incentive payments to 2.0 percent for 2009 and 2010. Financial incentives also will be paid to physicians who are "successful electronic prescribers."

The Act expands access to primary care services by physicians participating in the Medical Home Demonstration Project authorized by the Tax Relief and Health Care Act of 2006 (PubLNo 109-432) to provide coordinated, family-centered care to high-need populations.

DME competitive bidding programs delayed. The Act repeals a competitive acquisition demonstration project for clinical laboratory services that was authorized by Social Security Act §1847(e), and delays the implementation of the durable medical equipment (DME) competitive acquisition program under §1847(a) for 18 months. In addition, it terminates all contracts that have been awarded under this program and requires the Secretary to conduct the first round of bidding in 2009. The second round of competitive bidding will be slated for 2011. The cost of the delay of the DME competitive bidding program will be offset by a 9.5 percent cut in the Medicare reimbursement rate for items and services that are qualified for the competitive bidding program.

Other Medicare payment changes. Other Medicare payment and policy provisions (1) extend and improve rural access to Medicare services, including ambulance services, and provide state grants for mental health services or other health care services for veterans; (2) authorize pilot projects to increase awareness of and screening for chronic kidney disease and coverage of kidney disease education services; (3) provide a one percent update for 2009 and 2010 for end stage renal dialysis;

and (4) require the Secretary to develop a bundled payment system for end stage renal dialysis that will be phased in over four years beginning on January 1, 2011.

Medicare Advantage, prescription drugs and miscellaneous changes. MIPAA requires nearly all MA private fee-for-service (PFFS) plans to contract with a network of health care providers to continue to operate in an area that has two or more networked plans. The Medicare Advantage Stabiliza-

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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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Medicare (cont.)

tion Fund will be reduced from \$1.79 billion to a balance of \$1 to offset the costs of this change. The act phases out the duplicate payment to MA plans and retains the indirect medical education (IME) payments to hospitals by 2010.

With respect to Medicare Part D: (1) Medicare prescription drug plans will be required to provide payment to pharmacies within 14 days for electronic claims; (2) barbiturates and benzodiazepines will be added to the list of medications covered by Medicare Part D effective January 1, 2013; and (3) the use of claim data will be allowed for Congressional oversight, monitoring, making recommendations and analysis of the Part D program.

Medical assistance and related provisions. Transitional Medical Assistance (TMA) and the Abstinence Education Program are extended through June 30, 2009. Authorization for the Qualified Individuals (QI) Program, which pays outpatient care premiums for seniors with incomes just above the poverty level, and the Temporary Assistance for Needy Families (TANF) supplemental grants to states are extended through 2009.

The Act expands access to the low-income subsidies by exempting from the asset determination the value of an individual's life insurance policy. In addition, MIPAA requires an increased amount of information to be distributed to seniors who potentially are eligible for the subsidies and eliminates the late enrollment penalty for subsidy eligible individuals.

Grants to states for increasing the delivery of mental health services or other health for veterans returning from war will be authorized.

CBO analysis. The Congressional Budget Office (CBO) estimates that the legislation will decrease enrollment in MA plans by about 2.3 million individuals in 2013. It projects that under current law about 14.3 million people will be enrolled in MA plans in 2013 and that under the legislation about 2.3 million people will switch to traditional fee-for-service plans. CBO estimates that the phase-out of IME payments to MA plans and the requirement that PFFS plans establish provider networks for both individual and employer-group will

reduce federal spending by \$12.5 billion from 2009 to 2013 and \$47.5 billion over the 2009-2018 period. ■

CCH Washington Bureau, July 9, 2008.

2009 update to OPPS and ASC payment system released

Projected payments under the outpatient prospective payment system (OPPS) for calendar year (CY) 2009 are expected to rise to \$28.7 billion, and projected payments for services at ambulatory surgery centers (ASC) will be \$3.9 billion in CY 2009, according to an advance release of a CMS *Proposed rule*. The increase in the OPSS includes a 3.0 percent annual inflation update for most services. Current law does not allow for an inflation update to the ASC payment rate.

Hospitals that fail to report data on seven quality measures in CY 2008 will only receive a one percent inflationary increase for services provided in CY 2009. Four new quality measures will be added for CY 2009, which hospitals must report if they want to receive the full inflation increase in CY 2010. Public comment is being sought on 18 other possible quality measures that could be added for services provided in CY 2010. During CY 2010, CMS has proposed to randomly select 50

records of services provided during CY 2009 at 800 randomly selected hospitals to validate the accuracy of reported data. In addition, CMS is seeking comments on options for modifying payments for treating conditions that generally are preventable if providers follow established guidelines. A similar policy is in place for services provided for an inpatient stay.

OPPS changes. A new payment rate has been proposed for services provided at type B emergency departments, which are defined as emergency departments that are not open 24 hours a day, seven days a week. A single ambulatory payment classification (APC) payment will be made when two or more imaging procedures using the same imaging modality were provided in a single session. Separately payable drugs and biologicals will be paid at the average sale price plus four percent. In addition, cost reports will be modified to establish two cost centers for reporting drugs with high and low overhead costs. Two payments have been proposed for partial hospitalization program rates; one for days with up to three services and one for days with four or more services.

A hospital would be eligible for an outlier payment in CY 2009 if the cost of furnishing the item or service exceeds 1.75 times the APC payment rate, as well as a fixed dollar threshold of \$1,800.

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An analysis of the new Schedule H (IRS Form 990) and proposed instructions: Are hospitals ready for increased disclosures? Part I

By Albert Y. Lin, LLM, CPA, Health Care Compliance Advisory Board Member

“An ounce of prevention is worth a pound of cure.” Borrowing from Benjamin Franklin's proverb and the oft-repeated mantra of health care professionals, a thorough understanding of the newly-finalized Schedule H (Hospitals) of Form 990, Return of Organization Exempt from Federal Income Tax, may save the compliance officer and hospital tax advisors a lot of stress when the first full Schedule H is due in 2010 for the 2009 calendar year activities.¹

Subsequent to the original release of the redesigned Form 990 on December 20, 2007, draft instructions followed on April 7, 2008, and the Internal Revenue Service (IRS) Exempt Organizations Division solicited public comments through June 1, 2008.²

This Article focuses on the new Schedule H, which, while deceptively brief at four pages, results from demands for more transparency and consistency in reporting exactly how hospitals fulfill the general charitable purposes requirement for tax-exempt hospitals. The new Schedule H itself is broad; the underlying 2008 Schedule H Form 990 Instructions - Draft (“Draft Instructions”) and accompanying Worksheets, designed to help calculate requested figures related to charity care and community benefit, contain far more instructive guidance. The Draft Instructions should be finalized later in 2008 as the IRS disseminates the public comments.

The discussion, which will be presented in two parts, outlines the various provisions of the new Schedule H, and provides guidance for the compliance officer preparing for these new disclosures.

I. Who Must File

Line 20, Part IV of the new Form 990 triggers the Schedule H requirement - if the reporting charitable organization “operate[s] one or more hospitals.” The Draft Instructions define a hospital as

a facility that is, or is required to be, licensed or certified in its state as a hospital, regardless of whether operated directly by the organization or indirectly through a disregarded entity or joint venture taxed as a partnership . . . [h]owever, charitable organizations should not report on Schedule H information from a hospital operated by a separate tax-exempt or taxable corporation.³

“Group” return Form 990 files report information on Schedule H from all hospitals operated by a member of the group.⁴

A “facility” is defined later in the Draft Instructions for the Part V questions as

a campus (or component thereof), building, structure, or other physical location or address at which the organization provides medical or hospital care, including a hospital, outpatient facility, surgery center, urgent care clinic, or rehabilitation facility,

whether operated directly or indirectly.⁵

II. Reporting Charity Care and Certain Other Community Benefits “at Cost”

The first question on Part I, Charity Care and Certain Other Community Benefits at Cost, solicits fundamental information about the organization's charity care policy. Addressing a common complaint of consistency in definitions, the Draft Instructions provide that “charity care” does not include:

- (i) bad debt or uncollectible charges that the hospital recorded as revenue but wrote off due to failure to pay by patients who did not qualify for charity care, or the cost of providing such care;
- (ii) the difference between the cost of care provided under Medicaid or other means-tested government programs or under Medicare and the revenue derived therefrom; or
- (iii) contractual adjustments with any third party payors.⁶

In addition, these amounts are “at cost,” meaning that, in general, it is not the fair market value of charity care being reported, but rather the cost of providing such care. Question 2 applies to multiple hospital entities and asks if the written charity care policy applies uniformly or is tailored.

a. Eligibility Criteria for Free or Discounted Care

Question 3 asks information about charity care eligibility criteria. Specifically, if the Federal Poverty Guidelines (FPG) are used to determine eligibility for free or discounted care to low income individuals, the IRS requests disclosure of the family income limit for eligibility for free and discounted care. For example, if a patient's family or household income must be less than 250 percent of the FPG for the patient to qualify for free care, 250 percent is checked. Absent use of the FPG to determine eligibility, the IRS requires the filing organization to explain the income-based criteria (or, if applicable, asset-based tests) for determining free and discounted care.

Question 4 asks if the policy provides free or discounted care to the "medically indigent." The Draft Instructions define "medically indigent" to mean persons whom the organization has determined are unable to pay some or all of their medical bills because their medical bills exceed a certain percentage of their family or household income or assets (due to catastrophe, for example), even though income or assets exceed the charity care policy eligibility threshold.⁷

b. Budgets and Public Disclosure

Question 5 relates to budgetary issues - whether the organization budgets amounts for the free or discounted care provided by the charity care policies, and whether the actual charity care expenses exceeded budget. Moreover, the IRS asks disclosure of whether the organization was unable to provide for free or discounted care to otherwise eligible patients due to budgetary considerations.

Question 6a and 6b ask if the organization prepares an annual community benefit report, and whether it is made available to the public. The Draft Instructions suggest that if such community benefit report is not reported to a state agency, it may post the report on its web site or distribute the report by mail or at its facilities.⁸

c. Calculation and Disclosure of Costs

Question 7, Charity Care and Certain Other Community Benefits at Cost, consists of a table that will require considerable thought and planning. For the first time, detailed and attempted consistency in reporting for these components arise in a federal tax return, although there is no strict benchmark or minimum standard required. Amounts from eight categories⁹ of what the IRS considers quantifiable charitable activities are requested, with total, net, and percentage amounts within each activity also reported. The Draft Instructions emphasize that costs are to include both direct and indirect (i.e. allocable) costs.

The IRS suggests that Worksheets provided in the Draft Instructions be used to assist calculation of these amounts, but such Worksheets are not required nor should they be filed.

These Worksheets, or equivalent documentation, should be retained as supporting documentation.¹⁰

The Draft Instructions are difficult to follow at this point because they require the reader to flip back and forth between the Draft Instructions and the Worksheets. While the Worksheets are not required, following the Worksheets appears convenient since each Worksheet helps calculate amounts for every row and corresponding column.

Line 7a, Charity Care at Cost. The filing organization may calculate "charity care at cost" by one of two methods.

(i) The organization may use Worksheet 1.¹¹ Worksheet 1 begins by calculating the "total community benefit expense." The result is obtained by taking the product of (a) gross patient charges written off to charity care pursuant to charity care policies (with total charges at full established rates for patient care before deductions), and (b) a ratio of patient care cost to charges. Worksheet 2 (a subpart to Worksheet 1) shows how to determine the "ratio of patient care cost to charges" by calculating a percentage. The numerator is "patient care cost," calculated by taking the total organization operating expenses, and subtracting nonpatient care activities, Medicaid or provider taxes, and total "other" community benefit expenses (drawn from Line 7e, f, h, and i (such that these "other" community benefit expenses are not double-counted towards charity care act cost)).¹² The denominator is "patient care charges," calculated by taking the total gross patient charges and subtracting any gross charges for the community benefit activities described above. Worksheet 2 generally is a global formula-type of calculation that also is used for other parts of this community benefit section.

(ii) Alternatively, the organization may calculate "charity care at cost" by using equivalent documentation that "substantiates the information reported consistent with the methodology required" by the Worksheets.

Essentially, this methodology reports charity care not on a gross charge basis, but on a cost basis.

Worksheet 1 also provides spaces for calculating direct offsetting revenue (Line 7a, column d). Direct offsetting revenue is considered to be revenues from uncompensated care pools or programs, meaning payments received from a state, including Medicaid disproportionate share hospital (DSH) funds paid as direct offsetting revenue for charity care or to enhance Medicaid reimbursement rates for DSH providers. Spaces are provided for calculating net community benefit expense (Line 7a, column d), as well as the percentage of total expense (column f).

Disclosure of the actual number of activities or programs, and persons served, throughout Line 7 is optional.

Line 7b, Unreimbursed Medicaid, and Line 7c, Unreimbursed Costs - Other Means-Tested Government Programs. The organization is required to report the net cost of Medicaid and other "means-tested government pro-

grams.” “Medicaid” is defined generally as the United States health program for individuals and families with low income and resources; other “means-tested government programs” encompass any government-sponsored program by which eligibility is determined by income or asset level, including the State Children’s Health Insurance Program.

Worksheet 3 includes guidance to report the “net cost” of these programs.¹³

The gross patient charges from these programs provide the starting point. Then the same “ratio of patient cost to charges” as was determined in Line 7(a) is applied to the gross patient charges from such programs. In addition, Medicaid or provider taxes are added to the resulting figure to determine total community benefit expense under this Line 7b. The Draft Instructions note that if payments are received from an uncompensated care pool or Medicaid DSH program primarily to offset the cost of Medicaid services, the payments are entered in Worksheet 3; if the intent is to offset charity care, the payments are reported in Worksheet 1. Adjustments also are available for costs associated with Medicare direct graduate medical education costs.

Line 7e, Community Health Improvement Services and Community Benefit Operations. Line 7e provides the opportunity to disclose indirect forms of health-related community benefit that do not generate inpatient or outpatient bills. More specifically, these programs are “activities or programs carried out or supported for the express purpose of improving community health that are subsidized by the health care organization.”¹⁴

The Draft Instructions cite several examples, including activities or programs broadly accessible to the public that serve low-income consumers, reduce barriers to access, address governmental health priorities, leverage or enhance public health priorities, lessen the burden of government or another tax-exempt organization, or advanced knowledge that can be generalized through education or research that benefit the public. Worksheet 4 provides assistance in reporting these activities.¹⁵

The activities reported on this line do not include activities or programs provided primarily for marketing purposes or programs that are more beneficial to the organization as opposed to the community (i.e. designed primarily to increase referrals of patients with third-party coverage, required for licensure or accreditation, or restricted to an individual affiliated with the organization). The Draft Instructions require a demonstrated community need for such activities or programs, and such demonstrated need can be supported internally by assessments, documentation, or involvement of unrelated, collaborative tax-exempt or government organizations as partners.¹⁶

Line 7f, Health Professions Education. Line 7f requires that the net cost of health professions education be reported as a community benefit; however, the Draft Instructions and the accompanying Worksheet 5¹⁷ state that the costs exclude costs to educate or train the organization’s own employees or medical staff, or scholarships provided thereto. Exceptions

are provided on a facts and circumstances basis; for example, if the education and training for the organization’s own employees is also open to all community members, reasonable allocations of such costs may be made.

Line 7g, Subsidized Health Services. Entries for this question, using Worksheet 6,¹⁸ report amounts for “clinical services provided despite a financial loss to the organization.”¹⁹

This calculation may be somewhat confusing as it does not include costs associated with bad debt (never a component of charity care), charity care itself, or Medicaid and other means-tested government programs, for which such costs are reported elsewhere. The subsidized health services must be provided because of an identifiable community need. The IRS defines these as including qualifying inpatient programs (neonatal intensive care, addiction recovery and inpatient psychiatric units) and ambulatory programs (emergency services, satellite clinics in low-income communities, and home health programs). They, however, do not include ancillary programs (supporting inpatient and ambulatory programs) such as anesthesiology, radiology, laboratory departments, physician clinic services, and skilled nursing facilities. The American Hospital Association has objected in particular to the exclusion of reporting subsidized costs of physician clinic services, skilled nursing facilities, and ancillary programs, citing the express community need of these services in low-income communities.²⁰

Line 7h, Research. Line 7h of the table requires the organization to report as a community benefit the net cost of research. Such research must have the goal of producing generalizable knowledge made available to the public by communication of findings and observations, such as publication in a medical journal.²¹

Such research can be about underlying biological mechanisms of health and disease, natural processor principals affecting health or disease, or behavioral or sociological studies relating to health, delivery of care, or prevention. Costs can include salaries and benefits of researchers and staff, facilities, equipment, supplies, compliance costs, and dissemination costs. Worksheet 7 provides calculation assistance.²²

Commentators have noted that this question creates some issues because research may be borne by separate medical schools or research organizations that will seek ways to ensure proper “credit” for such activities are reflected on Schedule H.²³

Line 7i, Cash and In-Kind Contributions to Community Groups. Amounts entered on in Line 7i report, as community benefit, any cash or in-kind contributions made to health care organizations or other community groups. These reported contributions are typically “restricted grants,” i.e. restricted for the purpose of providing for the same charity care and community benefit activities reported throughout Line 7.²⁴

Restricted grants from related organizations are excluded. In-kind contributions may be the cost of hours donated by staff, indirect cost of space donated to tax-exempt community groups, and financial value of food, equipment, and supplies. Worksheet 8 may be used to document this component.²⁵

Conclusion

Part I of this Article introduced the new Schedule H that tax-exempt hospitals and hospital systems will need to file beginning with the 2008 tax year (with only a part required for 2008 and the full Schedule H to be completed for the 2009 tax year). It focused on the detailed charity care and community “cost” reporting requirements, and guides the compliance officer through a discussion of the Schedule H itself and the accompanying Draft Instructions and Worksheets. Part II of this Article will cover the remainder of Schedule H, which will include reporting of bad debt, Medicare, and collection practices, as well as management company, joint venture, and facility disclosures. ■

Albert Y. Lin, LLM, CPA is a partner at the Austin office of Brown McCarroll, LLP, where he practices in the firm's corporate/tax, and health care groups. 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 and Compliance for Health Care: A Practical Guide. He may be contacted at 512-703-5726 or alin@mailbmc.com.

- ¹ The new Form 990 and accompanying new Schedule H is first used for 2008 taxable years; however, only Part V, “Facility Information,” is mandatory for such year. Part I, Charity Care and Certain Other Community Benefits at Cost; Part II, Community Building Activities; Part III, Bad Debt, Medicare, & Collection Practices; Part IV, Management Companies and Joint Ventures; and Part VI, Supplemental Information; are optional for the 2008 taxable year.
- ² The redesigned Form 990 and Draft Instructions are available at: <http://www.irs.gov/charities/article/0,,id=181091,00.html>. The public comments have been made available at <http://www.irs.gov/charities/article/0,,id=181965,00.html>. Note that the “old” redesigned Schedule H originally was issued as of June 14, 2007 (identified by “20XX”), at the upper right corner, and was superseded by the December 19, 2007, version (with “2008” at the upper right corner).
- ³ Draft Instructions p. 5.
- ⁴ The Draft Instructions note that foreign hospitals are not to be included on Schedule H, although foreign joint ventures and partnerships must be included in reporting joint venture information on Part VI. The American Hospital Association (AHA) has suggested to the IRS that foreign hospital activity be permitted and reported on all Parts of Schedule H. See Letter from American Hospital Association to IRS, p. 2 of 9 (May 15, 2008), available at <http://www.aha.org/aha/letter/2008/080515-cl-irs-990.pdf> (hereinafter “AHA Letter”). The Minnesota Hospital Association, the California Hospital Association, and the Healthcare Financial Management Association (HFMA) also provided comments

and voiced similar concerns and suggested solutions similar to what the AHA Letter proposed (available at the public comments posted at the IRS web site, see *infra* n. 2).

- ⁵ Draft Instructions p. 13.
- ⁶ Draft Instructions p. 5.
- ⁷ Draft Instructions p. 6.
- ⁸ *Id.*
- ⁹ The best way to review the eight categories discussed below is to print out Schedule H, the Draft Instructions and the Worksheets for reference while reviewing this Article. Lines 7d, 7j, and 7k are not included in the discussion because they report totals only.
- ¹⁰ The AHA comments that many of its member hospitals have developed or licensed programs to capture community benefit information pursuant to state law, and recommends that the IRS clarify that reporting based on information provided by such programs are “equivalent documentation.” AHA Letter p. 2.
- ¹¹ Instructions on calculating this portion (with Worksheet 1) are found at p. 8 and p. 16 of the Draft Instructions.
- ¹² The AHA requested the IRS to clarify that Medicaid provider taxes are entered on Worksheet 1 if intended primarily to offset the cost of charity care as opposed to offset the cost of Medicaid services (recognizing state differences in application of Medicaid provider taxes). AHA Letter p. 4.
- ¹³ Worksheet 3 guidance is provided at pp. 17-18 of the Draft Instructions.
- ¹⁴ Draft Instructions p. 19.
- ¹⁵ *Id.* p. 18.
- ¹⁶ *Id.* p. 19.
- ¹⁷ *Id.* pp. 20-21.
- ¹⁸ *Id.* pp. 21-22.
- ¹⁹ *Id.* p. 21.
- ²⁰ AHA Letter p. 5.
- ²¹ Draft Instructions p. 22.
- ²² *Id.* pp. 22-23.
- ²³ See Comments from Keith Hearle, President, Verite Healthcare Consulting, LLC to the IRS, May 31, 2008, available at the IRS web site (*supra* n. 2).
- ²⁴ The AHA believes the Draft Instructions could explain the requirements in this section better because it is unclear whether grants received should be counted as direct offsetting revenue. AHA Letter p. 3. One commentator has pointed out that if restricted grants are not counted as direct offsetting revenues, smaller organizations that historically have not received such grants will appear to bear a smaller net community benefit expense. See *supra* n. 23.
- ²⁵ Draft Instructions p. 23.

Medicare (cont.)

CMS estimates that in CY 2009, nearly 25 percent of services provided under the OPSS will have a coinsurance amount equal to 20 percent. Overall, CMS estimates that beneficiaries will be responsible for roughly 23 percent of total payments for Medicare covered outpatient services in 2009.

ASC changes. Nine new surgical procedures will be added to the ASC payment system, according to the *Proposed rule*, and five new procedures to the list of office-based procedures. This includes three new procedures and six procedures that were previ-

ously excluded. The ASC payment system is in the second year of a four-year transition.

The *Proposed rule* was published in the *Federal Register* on July 18. ■
CMS Advance Notice of Proposed Rulemaking, July 3, 2008.

Anti-kickback

Gift card plan would not violate Stark law

A health care system that would provide \$10 gift certificates to patients whose service expectations were not met would not be providing prohibited remuneration under 42 U.S.C. §1320a-7a, according to an Office of Inspector General (OIG) advisory opinion.

Elements of the proposal. Under the health care system's proposed gift card plan, \$10 gift cards from local vendors, such as restaurants and theater chains, would be provided to patients with complaints about service shortfalls, including excessive wait times, cancelled appointments, delayed meals, excess noise, housekeeping, dietary concerns, equipment problems, and loss of personal items. The gift cards would not be redeemable for health care items or services at places like pharmacies or durable medical equipment suppliers. The health care system would track the issuance of gift cards under the program to make sure that no one patient receives more than \$50 worth of gift cards within one year and to identify service areas that need improvement. In addition, the gift card program would not be advertised.

Under 42 C.F.R. § 1003.102(b)(13), civil monetary penalties are imposed against a person for giving something of value to a Medicaid or Medicare beneficiary if the benefactor knows that the gift would influence the beneficiary's choice of a provider or supplier of an item or service for which Medicaid or Medicare would pay for all or part of the service or item. Such benefactors also may be excluded from federal health care programs by the OIG. The health care system's proposed program would not violate the anti-kickback statute because it would not provide gift cards for services or items redeemable at health care providers and suppliers and the gifts would not exceed \$50 per patient within a year. ■

OIG Advisory Opinion, Doc. No. 08-07, June 27, 2008, Health Care Compliance Reporter, ¶500,186.

In the News

McNulty memo under further pressure

The attorney-client privilege waiver policy at the Department of Justice (DOJ), the "McNulty Memorandum," is coming under pressure to be revised, following communication between Deputy Attorney General Mark Filip and members of the Senate Judiciary Committee. In a letter response, Sen. Arlen Specter (R-Pa.), ranking member of the committee, expressed concern about the delay in enacting legislation while the DOJ continued to act under the McNulty Memo. Among his concerns were individuals incurring enormous attorneys' fees, including appellate litigation, while the guidelines were analyzed, vague revisions that did not address the waiver of privilege, and potential for future modifications by subsequent attorney generals. He recommended that the Judiciary Committee either come to some accommodation with the administration on legislation or have Congress move ahead on its own.

Response Letter of Sen. Arlen Specter to Deputy Attorney General Mark Filip, July 10, 2008.

Providers sentenced for Medicare fraud

A mother and her two daughters, the owners of four Miami-based healthcare corporations, were sentenced to prison for their roles in schemes to defraud the Medicare program for unnecessary medicine, durable medical equipment (DME) and home health care services. The family owned two DME companies, a home health company, and an assisted living facility. Under the scheme, patients were paid cash kickbacks for use of their Medicare cards, were falsely diagnosed with chronic obstructive pulmonary disease, and were prescribed unnecessary aerosol medications. In addition, co-conspirator pharmacies were paid more than \$14 million based on the submission of claims for medically unnecessary aerosols.

DOJ News Release, June 27, 2008.

Claims containing inactive physicians' identifiers targeted

Deputy Administrator Herb Kuhn assured lawmakers that CMS is working to prevent fraudsters from using the identification of deceased physicians to obtain payment on false Medicare claims. At a Senate Homeland Security and Government Affairs Investigations Subcommittee hearing, Kuhn said that CMS will be working with the Social Security Administration (SSA) to make sure this problem, estimated to have cost the program about \$100 billion, does not continue. From 2000 through 2007, Medicare payments for durable medical equipment claims that contained identification numbers assigned to deceased doctors ranged from an estimated \$60.3 million to \$92.8 million. The estimate includes only claims that occurred at least one year after the doctors' deaths. If claims within 12 months of the physicians' deaths were included, the estimate of claims paid over that timeframe would likely reach over \$100 million. CMS has implemented policy changes and procedures to prevent unscrupulous providers from using invalid or inactive personal identification numbers to bill Medicare. Under the new fraud-prevention system, CMS will match the names of physicians filing claims against the SSA's database of death reports. CMS also will conduct (1) periodic validations of claims, (2) onsite inspections, and (3) other checks for enrolled providers. In addition, National Provider Identifiers will be required to file a Medicare claim.

CCH Washington Bureau, July 9, 2008.