

CCH Health Care Compliance LETTER

Volume 12, Issue 16

health.cch.com

August 11, 2009

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A Compliance-Oriented Refresher on Nonprofit, Tax-Exempt Health Care Organization Tax and Accounting Developments

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Rules to consider under EMTALA, Medicare, state laws for emergency services

By Christopher Kenny, King & Spaulding, L.L.P., Washington, D.C.

For a variety of reasons, a hospital may elect to close its emergency department. In some instances, the department is underutilized, has costs disproportionate to revenue, and is not essential to the community because there are more utilized emergency departments at other hospitals. In other instances, hospitals believe that they can utilize the space in a more productive manner.

While Medicare conditions of participation do not require that an acute care hospital maintain an emergency department (42 C.F.R. §482 et. seq.), there are considerations that need to be taken into account if a hospital decides to close an existing emergency department. Two special classifications of hospitals, Medicare-dependent hospitals (MDHs) and sole community hospitals (SCHs), also are not required to maintain emergency departments (42 C.F.R. §485.108; 42 C.F.R. §412.92). Critical access hospitals (CAHs), however, must maintain emergency departments to retain their special classification (42 C.F.R. §485.618).

Acute care hospitals. The title to conditions of participation for emergency service departments lists emergency services as "optional hospital services" (42 C.F.R. §482.55). When adopting this regulation in 1986, the Health Care Financing Agency (the predecessor agency to the Centers for Medicare and Medicaid Services (CMS)) stated that the rules governing emergency services applied only to those hospitals "that choose to provide emergency services" (51 FR 22010, 22029, June 17, 1986). An acute care hospital will not lose its status as an inpatient facility for Medicare payment purposes if it were to close or otherwise not operate an emergency department.

Regardless of whether a hospital operates an emergency services department, Medicare places some emergency-related responsibilities on acute care hospitals. At a minimum, a hospital's governing body must ensure that the facility's medical staff has written policies and procedures for: (1) appraisal of emergencies; (2) initial treatment of emergencies; and (3) referral when appropriate (42 C.F.R. §482.12(f)(2)). In addition, Medicare expects the hospital to have clear plans to deal with any emergency patients that may present for care. Specifically, these policies should include: (1) who, by position, would react to an emergency; (2) which physicians should be called; (3) what procedures should be taken to stabilize a patient; and (4) how to arrange a transfer to a more suitable facility.

CMS does not view these steps as suggested or permissive. The agency has made clear that "the development and implementation of specific policies and procedures

EMTALA (cont.)

relating to the handling of emergencies in the absence of an organized service should be a mandatory rather than an optional requirement" (51 FR at 22030).

Additional CMS guidance has made clear that the agency expects hospitals to have in place procedures to treat already admitted patients who develop emergency needs while in the facilities. An April 26, 2007, memorandum (available at: <http://www.cms.hhs.gov/SurveyCertification-GenInfo/downloads/SCLetter07-19.pdf>) stated that hospital procedures must be sufficient to address emergency situations 24 hours a day, seven days a week — particularly for their own patients.

A registered nurse must be immediately available and able, through training and education, to assess a patient's need for emergency care and, if necessary, provide initial treatment. Policies must enable personnel to determine when a patient is in need of transfer to a suitable facility and to assure safe transfer of the patient, with necessary medical information, to an appropriate facility. This policy clarification came on the heels of numerous reports of specialty hospitals that resorted to calling 911 for an ambulance transfer to an acute care hospital when their own patients were in need of emergency care and the facilities were unable to provide even basic stabilization (for more information, see Reed Abelson, "Some Hospitals Call 911 to Save Their Patients," *New York Times*, April 2, 2007).

That said, hospitals without emergency departments can and should take reasonable steps to decrease the likelihood of handling emergency situations. These hospitals should not post signs or otherwise hold themselves out as emergency facilities, and they should alert local ambulance suppliers that they lack emergency departments.

These actions address a hospital's obligations under Medicare. State hospital licensure law may nonetheless require that a hospital maintain an emergency department. Texas, for example, requires in great detail that all licensed hospitals have an "emergency suite" (25 Tex. Admin. Code §133.41(e)) that includes an emergency treatment room, an observation area, a trauma center, and an emergency clinic (25 Tex. Admin. Code

§133.163(f)). Hospitals should research state law, regulations, and policy before taking any steps toward closing an emergency department.

Critical access hospitals. Unlike acute care hospitals, Medicare requires CAHs to maintain an emergency department. The CAH conditions of participation explicitly require CAHs to provide 24-hour emergency services (42 C.F.R. §485.618).

Equipment used in treating emergencies must be readily available, blood must be available directly at the CAH or under arrangements, and personnel meeting the qualifications set forth in the regulations must be nearby (within 30 to 60 minutes, depending on the CAH's geographic location and other factors), if not on site (42 C.F.R. §485.618).

CAHs are the first source of treatment for many beneficiaries in rural areas. These hospitals must be prepared to treat emergencies that present at their respective facilities, as transfer to an acute care facility may take longer and may be more complicated than for nonrural acute care facilities.

Medicare-dependent hospitals and sole community hospitals. The Medicare regulations set forth special treatment for several classifications of hospitals. MDHs (42 C.F.R. §412.108) and SCHs (42 C.F.R. §412.92) both receive payments using a different model than other acute care facilities under the prospective payment system. While the specific qualifications and payment methods for each hospital differ (for example, an MDH cannot also be classified as an SCH), both receive special treatment because of their rural location. Unlike CAHs, however, neither MDHs nor SCHs are required to have emergency departments to maintain their classification.

If MDH or SCH facilities choose to not maintain emergency departments, they nonetheless must have in place written policies and procedures to direct medical staff in assessing and stabilizing patients with emergencies and arrange transfers to acute care facilities that are able to offer appropriate treatment.

Conclusion. Depending on a hospital's classification under the Medicare regulations, operation of an emergency department may or may not be required. State licensure

law and regulations, however, may require a hospital to maintain an emergency department. Further, even if a hospital is not required to maintain an emergency department, it is required to fulfill its Emergency Medical Treatment and Active Labor Act (EMTALA) obligations and provide for the stabilization and safe transfer of patients who present at the facility with emergency medical conditions. ■

Reprinted from Dennis Barry's Reimbursement Advisor, Aspen Publishers, Aug. 2009, Vol. 24, No. 12



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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.

CCH Health Care Compliance Letter is published 24 times a year by CCH, a Wolters Kluwer business, 4025 W. Peterson Avenue, Chicago, IL, 60646. Subscription rate is \$305 per year. First-class postage paid at Chicago, Illinois, and at additional mailing offices. POSTMASTER: SEND ADDRESS CHANGES TO *CCH Health Care Compliance Letter*, 4025 W. PETERSON AVENUE, CHICAGO, IL 60646. Printed in U.S.A. ©2009 CCH. All rights reserved.

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Accident hazards, administrative deficiencies by SNF warrants penalties

A skilled nursing facility (SNF) was properly assessed with civil penalties due to its noncompliance with federal health and safety regulations. The SNF's responsibilities included, among other things, transporting its wheelchair-bound residents to appointments in a van that it owned and operated. The van was equipped with safety belts to secure residents in their wheelchairs during transport.

Resident injuries. In 2005, the driver of the van made a sudden traffic stop while transporting a wheelchair-bound resident. A witness found the resident on the van floor with no safety belt on and the wheelchair on top of him. The resident suffered minor injuries to his arm and shoulder. Another incident occurred in 2006, when the van driver noticed that the resident had slipped out of her wheelchair onto the floor. The driver stopped the van and unsuccessfully attempted to return the resident to her wheelchair. After consulting the SNF nurse on duty, the driver left the resident on the van floor and returned to the SNF. The resident was transferred to the hospital, where she died.

Investigation and penalties. The SNF was investigated and subsequently received a statement of deficiencies indicating it was not in compliance with 42 C.F.R. §483.25(h)(1), which governs hazards, and 42 C.F.R. §483.75, which governs administration. CMS assessed civil monetary penalties that totaled approximately \$270,000.

Regulation of motor vehicle travel. Contrary to the SNF's argument, HHS had the authority to issue citations to the SNF for violations resulting from the use of motor vehicles under 42 C.F.R. §483.25(h)(1). While neither the Social Security Act nor 42 C.F.R. §483.25 explicitly mentions motor vehicles, the regulation must be interpreted broadly to protect resi-

dents, and, thus, reasonably included van use by the SNF.

Evidentiary burden. The SNF argued that CMS erred when it required the SNF to demonstrate its compliance by a preponderance of evidence. According to the SNF, a burden-shifting framework applied to cases involving noncompliance with CMS regulations, and thus CMS, not the SNF, had the burden to show that the SNF was noncompliant.

The Fourth Circuit, however, noted that the burden-shifting framework applied only when the evidence stood in " equipoise " (equal balance). Given that there was substantial evidence of the SNF's noncompliance with the regulations, the evidence was not equally balanced. Therefore, the burden-shifting framework did not apply to the SNF's case.

Substantial evidence of non-compliance. The SNF was required to ensure that the resident environment was free of accident hazards under 42 C.F.R. §483.25(h)(1). The evidence revealed that the van's safety belts worked properly when buckled behind the wheelchair; but when the safety belts were buckled in front of the wheelchair, the resident risked sliding out of the wheelchair. The evidence

revealed that the SNF's staff consistently and improperly buckled the safety belts in front of the wheelchair, and that the SNF failed to address the foreseeable risks of misusing the safety belts, particularly in light of the injuries sustained by the residents.

The SNF was required to use its resources to maintain the well-being of each resident under 42 C.F.R. §483.75. A deficiency under this section was derivative of other deficiencies, including violations of 42 C.F.R. §483.25(h)(1) regarding accidents. In addition to its 42 C.F.R. §483.25(h)(1) accident violations, there was evidence that the SNF did not follow its own administrative procedures. For example, the SNF's corporate manual directed supervisors to investigate immediately any accidents to determine and eliminate the cause. The evidence, however, showed that the SNF neither inquired whether staff members used the safety belts properly, nor identified the cause of the accidents.

Notice. Finally, it was determined that the SNF was provided with timely notice that the improper use of its safety belts was the basis of the finding of its deficiencies. ■

SunBridge Care and Rehabilitation v. Leavitt, 4th Cir., No. 08-1603, July 22, 2009

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A Compliance-Oriented Refresher on Nonprofit, Tax-Exempt Health Care Organization Tax and Accounting Developments

by Albert Lin, Brown McCarroll, L.L.P.

On June 6, 2009, in a radio speech during his visit to Europe, President Obama fast-tracked his commitment to comprehensive health care reform – a precursor to the major health care legislation being debated this summer. "We must attack the root causes of skyrocketing health care costs. Some of these costs are the result of unwarranted profiteering that has no place in our health care system, and in too many communities, folks are paying higher costs without receiving better care in return . . . [we] should learn from their successes and promote the best practices, not the most expensive ones."

As focus upon, and change within, the existing United States health care system remains in the forefront of regulatory and media scrutiny, the nonprofit, tax-exempt hospital organization would benefit from a summary of current tax compliance areas of concern in the past year. These areas include: (1) recent voluntary - but for practical intents and purposes, mandatory - compliance surveys sent to nonprofit hospitals from the Internal Revenue Service ("IRS"); (2) final revised Form 990 and Instructions; and (3) Financial Accounting Standards Board Interpretation No. 48 ("FIN 48") audit compliance reminders. This article intends to serve as a "bird's eye" summary of these developments, providing recommendations for preventive maintenance and ultimately preparing the tax-exempt, nonprofit hospital for broader reforms.

Lessons from IRS Compliance Checks: Review Governance Documents, Assess Policies and Procedures, Evaluate Board Effectiveness

IRS compliance checks are neither formal audits nor examinations; rather, they are informal surveys by the IRS to determine if an entity is adhering to standard IRS record-keeping and reporting requirements.¹ While participation is voluntary, the IRS notes that failure to respond may trigger a formal audit or investigation. As such, responses to a compliance check request should never be ignored, and careful attention should be paid to all responses.

Currently, three key compliance check projects are of particular interest to the tax-exempt health care compliance officer. First, a Final Report was issued in February 2009 on

a compliance check questionnaire sent to over 500 nonprofit hospitals in 2006 ("Hospital Compliance Check").² Second, in September 2008, the IRS issued an interim report on the results of another compliance check questionnaire sent in 2007 to charitable organizations receiving tax-exempt bond proceeds ("Tax-Exempt Bond Compliance Check").³ Finally, a third initiative is underway through compliance checks sent in January 2009 to governmental issuers of tax-exempt bonds ("Governmental Issuer Compliance Check").⁴ These compliance checks were keyed towards specific areas of concern. These areas and recommendations to address them are discussed below.

Key Areas of Concern Drawn from the Hospital Compliance Check

The original Hospital Compliance Check focused on community benefit and executive compensation in nonprofit, tax-exempt hospitals. The Final Report was meant simply to provide data to the public as opposed to drawing hard conclusions. The general consensus with respect to community benefit was that the overall average of total revenues spent on aggregate community benefit was 9 percent, with a median at 6 percent. But such percentages were based on varying methods of calculating community benefit. The Report noted that the new Schedule H to Form 990⁵ would assist in remedying these variations so future data would be more informative. With respect to executive compensation, a small subset of twenty large hospital systems were reviewed for excess compensation. Of these hospitals, the average total compensation (base salary, bonus, benefits) was \$801,720, and the average Chief Executive Officer compensation was \$1.4 million. Eighty-five percent of these hospitals properly used

comparability data and independent personnel to review and establish the compensation amounts.

While that compliance check is closed, the nonprofit, tax-exempt health care compliance officer should ask if his or her system's organizational structure, controls, policies and procedures are sufficient to respond to inquiries based on the areas below. These questions eventually were reflected in the new Schedule H and will be required to be disclosed in future years (most reporting is optional currently).

Information on charity care. Can internal accounting measure, in terms of costs and number of patients, the provision of medical services to patients with private/public/no insurance, Medicaid, and Medicare? Can data be provided with respect to inpatient and outpatient treatment? Can denial of treatment to patients on the basis of private/public insurance, Medicaid, and Medicare be substantiated? Have the emergency room admission policies been reviewed in recent years?

Information on board of directors. How many directors serve on the Board? Is the number sufficient or excessive? Does the composition of the Board reflect a sufficiently diverse cross-section of community representation, expertise, and other characteristics reflecting diversity and capacity? Are the number of meetings adequate? Is the Board accountable for its actions, reflected by written ethics and conflicts of interest policies?

Medical staff privileges. Are all qualified physicians in the community eligible for medical staff privileges at the hospital? If not, what are the parameters?

Medical research. What amounts of public and private funding go to the hospital's medical research programs and medical trial programs? Does the hospital provide funding to outside individuals or organizations? Are the research findings publicly disseminated, or is access limited?

Continuing medical education. Does the hospital provide continuing medical education programs? Does the hospital track whether funding for the programs comes from public or private sources?

Uncompensated care. Is there a written policy for the provision of medical care to those who cannot pay? Does the hospital maintain records on how many patients received such uncompensated care, and can it calculate how much was spent with respect to uncompensated care? Is uncompensated care determined by taking the excess of the amount charged for the service less private/public insurance, Medicaid, Medicare, and patient payments? Are bad debts treated as uncompensated care? What other items, other than the excess described here, are treated as uncompensated care? Is uncompensated care provided for inpatient, outpatient, or emergency room care?

Billing practices. What are the written billing policies for inpatient, outpatient, and emergency room patients? What are the time periods relating to invoicing and due dates? Does

the hospital use collections agencies? Does the hospital offer installment or other extended pay arrangements? Do hospital charges vary depending upon whether the patient has private/public insurance or level of income?

Community programs. Are community health programs offered to the public (i.e., medical screening programs, immunization programs, lectures, seminars, healthcare needs assessments, newsletters)? Are fees charged for these programs? How much is spent annually on these programs?

Compensation practices. Does the organization's accounting department accurately compile salary/compensation, deferred compensation, and benefit breakdowns for officers, directors, trustees, key employees, and independent contractors? Is there a written compensation policy and a conflicts of interest policy? How is compensation determined? Are outside consultants utilized? What comparability factors are used? Is there a mechanism in place to identify instances in which there are business relationships between the organization and its officers, directors, trustees, or key employees?

Key Areas of Concern Drawn from the Tax-Exempt Bond and Governmental Issuer Compliance Checks

With many nonprofit, tax-exempt organizations obtaining financing through tax-exempt bonds, it becomes especially important for the compliance officer to ensure the organization has sufficient mechanisms in place to satisfy the post-issuance requirements that must be met for tax-exempt bonds to remain tax-exempt as "qualified 501(c)(3) bonds." In brief, to maintain status as a "qualified 501(c)(3) bond," the tax-exempt organization must satisfy: (a) requirements related to the use of the proceeds and the financed property (i.e. the bond-financed property generally cannot be used for private business use); and (b) limits on the yield on the investments acquired with the proceeds (the bonds cannot be "arbitrage" bonds whereas the yield on investments acquired with the bonds exceed the yield on the bond issue itself). The second requirement is a bit difficult to understand, but in brief, proceeds from tax-exempt bonds are not supposed to be invested in property that generates a yield that exceeds the interest rate charged to the borrower of the bond proceeds.

In 2007, the IRS sent the "Tax-Exempt Bond Financing Compliance Check Questionnaire" to over 200 organizations that reported a tax-exempt bond obligation on their 2005 Form 990. The purpose was to determine how many of these organizations: (a) had post-issuance compliance procedures in place (95 percent reported they had, but only 16 percent of those responding had written procedures); (b) assigned a management official the primary responsibility for monitoring bond issuance requirements (89 percent did); and (c) whether the books and records were sufficient to substantiate require-

ments (97 percent stated yes). In January 2009, the IRS sent a similar questionnaire to the governmental entities issuing the bonds. In light of these compliance checks, the compliance officer (particularly those unfamiliar with the technicalities of the tax-exempt bond process) should assess whether internal controls exist to handle the following areas of IRS concern.

Post-issuance compliance. Does the organization have a written procedure or guideline to ensure the qualified 501(c)(3) bond financing proceeds, after the issuance closes, remain in compliance with requirements relating to the: (1) proper and timely use of proceeds and bond-financed property; (2) arbitrage yield restrictions; and (3) timely filing of any applicable tax returns?⁶ Is there a primary person responsible for monitoring these requirements? Are there training or educational resources available for such persons?

General recordkeeping. Are records maintained with respect to the tax-exempt bonds? How long and in what medium are they maintained?

Investments and arbitrage compliance. Is there documentation of allocation of the investment earnings between general investments and bond financing investments? Is there documentation relating to investment contracts, credit enhancement transactions, and financial derivatives? Are copies maintained of arbitrage-related documents such as computations of bond yield, rebate, and yield reduction payments? Are there written procedures or policies for monitoring these requirements?

Documentation of expenditures and assets relating to financings. Does the organization maintain documentation of allocation of the use of bond financing proceeds? Are there copies of requisitions, draw schedules, draw requests, invoices, and checks relating to bond proceeds spent during the construction period? Are there copies of construction, renovation, and/or purchase of the bond-financed facilities? Is there a list or schedule of all bond-financed facilities or equipment?

Private business use. Are records maintained of all unrelated trade or business activities allocated to bond-financed facilities, as well as activities by third parties allocated to bond-financed facilities? Are there joint venture agreements, management agreements, naming rights, subleases, or other arrangements with respect to the facilities? Generally, what is the process by which the organization ensures the qualified 501(c)(3) bonds remain tax-exempt?

Preparation for the Revised Form 990 and Schedule H: Assess Governance and Internal Accounting Systems

Plenty of articles and commentary cover the extensive revisions to IRS Form 990 (Return for Organization Exempt from Income Tax); this brief article does not purport to cover the revisions in detail as by now the nonprofit, tax-exempt compliance officer knows of the revisions. Instead, it is a reminder as to what constitutes "best practices." Rather than dwell on the details of completing the new Form 990 and related Schedules, the compliance officer might directly ask the following questions.

- (1) Has the structure, organization, and effectiveness of the governing body (Board of Directors or Board of Trustees and officers) been assessed?** Section VI of the new Form 990 contains more detailed questions relating to the organization of the governing body and management of the exempt organization. If the organization has not reviewed or otherwise evaluated the Board's structure and effectiveness, the compliance officer may suggest such a review and refer to new Form 990, Section VI (Governance, Management, and Disclosure) questions as a guideline.⁷ Key written documents that may be added include conflicts of interest policies (and especially the ability to monitor and enforce the policy), whistleblower policies, and document retention and destruction policies. In addition, written compensation policies and documented efforts at establishing comparability data for executive compensation are recommended.
- (2) Is the Board and other leadership actively involved in assessing needs, setting community benefit standards, approving policies, and representing interests? Are internal controls and recordkeeping sufficient to track such activities?** New Schedule H (Hospitals) will require much more detailed community benefit data than previously requested by the IRS. While some information may be tracked for state requirements, the new IRS requirements may not necessarily be identical. The compliance officer should develop a good understanding of the data required for new Schedule H and be prepared to enlist active Board involvement in determining if the data and activities are sufficient (not simply for the IRS, which does not have minimum standards, but for the public and regulatory agencies).
- (3) Has there been a recent review or evaluation of all related entities or ventures within the organization?** Frankly, effective internal governance requires knowledge of all entities existing within a health care system. New Schedule R (Related Organizations and Unrelated Partnerships) solicits information relating to limited liability companies, partnerships, corporations, "disregarded" entities, and joint ventures with which the tax-exempt organization is involved. The compliance officer should have a clear understanding of all entities under the primary organization's umbrella (and not simply rely on outside counsel or accountants who may not always have adequate information). In larger organizations, it is surprising how many entities slip through the cracks.

Accounting for FIN 48: Work with Independent Auditor to Determine Compliance with FIN 48

The nonprofit, tax-exempt organization subject to audited financial statements will need to comply with Financial Accounting Standards Board ("FASB") Interpretation No. 48, entitled "Accounting for Uncertainty in Income Taxes: An Interpretation of FASB Statement No. 109." This accounting standard (referred to as "FIN 48") is a 58-page document⁸ that provides accountants a detailed process to measure and quantify "uncertain income tax positions." The standard may

be applicable to tax-exempt organizations that have issued tax-exempt bonds. Simply being tax-exempt is a "tax position" for the tax-exempt health care organization, so auditors will need to evaluate and disclose potential tax problem areas that come to light during their investigation. The compliance officer should be aware of the following key problem areas that can jeopardize tax-exempt status, and thereby give rise to FIN 48 disclosures.

- (1) **Failure to be organized and operated exclusively for charitable purposes.** Ensuring the organization's articles of incorporation/certificate of formation are updated and properly reflect IRS requirements helps satisfy the "organization" requirement of being tax-exempt. The "operated exclusively" requirement is far broader, but may be satisfied by paying attention to community benefit/care requirements, monitoring related party transactions, proper filing of tax returns, and other common sense due diligence matters. Failures to pay attention to these details can jeopardize tax-exempt status and give rise to FIN 48 disclosure issues.
- (2) **Participate in private inurement or material private benefit transactions.** The compliance officer can minimize problems by ensuring compensation and conflict of interest policies exist and are actively followed and enforced. Following comparability data and use of disinterested compensation consultants is practically mandatory for large, tax-exempt health care organizations. Careful attention should be paid not only to what meets legal requirements, but what may be perceived as improper by the public.
- (3) **Participate in prohibited political campaign activities or lobbying.** The compliance officer should be aware of political activity restrictions applicable to tax-exempt organizations. Not only are political campaign contributions prohibited under IRS rules, seemingly innocuous activities, such as an invitation to speak at the organization's facilities, can potentially violate these rules. The IRS published Revenue Ruling 2007-41,⁹ which outlines ways in which tax-exempt organizations can and cannot participate in voter education, voter drives, candidate appearances, and issue advocacy. The Revenue Ruling also discusses how individual officers and directors of an exempt organization may structure participation in campaigns in their individual capacity, as well as guidance on how web sites may or may not be linked to campaigns.
- (4) **Participate in excessive Unrelated Business Taxable Income ("UBTI") transactions.** UBTI is generated when an exempt organization participates in a business activity that does not further the organization's charitable purpose. For example, rental of an exempt organization's commercial property to a third party typically triggers UBTI - the exempt organization is taxed at regular corporate rates on net income generated from the activity. If the level of UBTI is substantial with respect to the overall net income of the exempt organization, the tax-exempt status of the organization becomes an issue. The compliance officer should review all of these issues with the organization's internal and external accounting staff, as well as legal counsel, to highlight any activities that might generate UBTI.

Conclusion

There has been a wealth of educational material summarizing recent tax and accounting developments in the nonprofit, tax-exempt organization area, and the detail can be a bit overwhelming. This article very briefly summarized the IRS compliance surveys, the final revised Form 990 and Instructions, and FIN 48 audit standard applicability. The article explained the general steps the nonprofit, tax-exempt compliance officer should take as a result of those developments. By having the proper "birds-eye" perspective, a better plan to handle the details can be implemented, making compliance with Form 990 and FIN 48 more manageable. ■

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 is a member the CCH Health Care Compliance Editorial Board. He may be contacted at 512-703-5726 or alin@mailbmc.com.

¹ See IRS Publication 3114, *Compliance Check, Audit, Examination, or Review* (Rev. 1-2005), available at <http://www.irs.gov/pub/irs-pdf/p3114.pdf>. The compliance check is authorized pursuant to §60501 of the Internal Revenue Code of 1986, as amended ("Code").

² See IRS Form 13790, *Compliance Check Questionnaire, Tax Exempt Hospitals* (Rev. 5-2006), available at http://www.irs.gov/pub/irs-tege/exhibit_1_form13790.pdf. A copy of the final report, along with an executive summary, is available at <http://www.irs.gov/charities/charitable/article/0,,id=203109,00.html>.

³ See IRS Form 13907, *Tax Exempt Bond Financings Compliance Check Questionnaire* (Rev. 8-2007), available at http://ftp.irs.gov/pub/irs-tege/form_13907_teb_financing_questionnaire.pdf. A copy of the interim report following these compliance checks is available at http://www.irs.gov/pub/irs-tege/interim_report_-_draft_09-11-08_v1.pdf.

⁴ See IRS Form 14002, *Governmental Bond Financings Compliance Check Questionnaire* (Rev. 9-2008), available at <http://www.irs.gov/pub/irs-tege/fl14002.pdf>. See also <http://www.irs.gov/taxexemptbond/article/0,,id=202946,00.html> for a detailed summary of the purposes.

⁵ See *On the Front Lines, An Analysis of the New Schedule H (IRS Form 990) and Proposed Instructions: Are Hospitals Ready for Increased Disclosures?*, CCH Health Care Compliance Letter, Part I, Vol. 11-15, July 22, 2008, and Part II, Vol. 11-16, Aug. 5, 2008.

⁶ With respect to tax returns, adequate books and records need to be maintained to support tax exemption of the interest as reported to the beneficial holders of the bonds. The issuer and conduit borrowers may need to file IRS Form 8038, 8038-G, 8038-GC, and other specialized forms. New Form 990's Schedule K also will solicit information from the tax-exempt organization that reports an outstanding tax-exempt bond issue that had an outstanding principal amount in excess of \$100,000 as of the last day of the tax year.

⁷ All final Form 990s and related Schedules are available at <http://www.irs.gov/charities/article/0,,id=176637,00.html>.

⁸ FIN 48 is available at <http://www.fasb.org/pdf/fin%2048.pdf>.

⁹ Rev. Rul. 2007-41, 2007-25 I.R.B., June 25, 2007, available at http://www.irs.gov/irb/2007-25_IRB/ar09.html.

Anti-Kickback

OIG approves bulk drug replacement program

An institutional patient assistance program (PAP) proposed by a pharmaceutical company that would make certain drug products available to outpatients without prescription drug coverage through the provision of replacement stock to certain participating disproportionate share hospitals would not constitute grounds for imposition of civil monetary penalties and administrative sanctions.

Hospital/physician inducements.

The Office of Inspector General's (OIG) central concern is whether the PAP would be a vehicle through which the company offers remuneration to induce the hospitals to purchase or order the company's products; or to influence the prescribing patterns of physicians. The OIG believes these risks are low because: (1) the manner in which hospitals would be invited to join the PAP would not be related to utilization of the company's products; (2) the PAP would be structured so that drugs merely pass through the hospitals, which safeguards against obtaining excess stocks; (3) hospitals would receive no administration, dispensing, or other fees; (4) the structure of the PAP would limit the risk that the company could influence physician prescribing patterns; and (5) the PAP would be transparent, with the terms documented in a written, signed agreement.

Beneficiary inducements. The OIG also examined the PAP for implications under §1128(a)(5) of the anti-kickback statute prohibiting inducements to beneficiaries. The OIG noted that pharmaceutical manufacturers are not "providers, practitioners, or suppliers" for the limited purposes of §1128A(a)(5), unless they also own or operate, pharmacies, pharmacy benefits management companies, or other entities that file claims for payment under the Medicare or Medicaid programs. Because the company has certified that it does not engage in these activities, the proposed arrangement would not implicate any beneficiary's choice of the company's products. ■

OIG Advisory Opinion, No. 09-08, July 28, 2009, Health Care Compliance Reporter, ¶1500,213

In the News

States set to survey ASCs to reduce HAIs

HHS Secretary Kathleen Sebelius has announced a nationwide effort to reduce health care associated infections (HAIs) in ambulatory surgical centers (ASCs). The effort will begin later this month in 12 states – Maine, New Jersey, Maryland, Florida, North Carolina, Indiana, Michigan, Arkansas, Oregon, Utah, Wyoming and Kansas – which will survey more than 125 ASCs before September 30, 2009, at an estimated cost of up to \$1 million. The onsite reviews, paid for out of Recovery Act funds, are designed to ensure that the facilities are following Medicare's health and safety standards. The initiative will employ a new CMS survey process that uses a tool developed in conjunction with the Centers for Disease Control and Prevention (CDC). An additional \$9 million will be available in October 2009 for all states to make additional inspections with the new, improved survey tool. The CDC also will make \$40 million available to state public health departments to create or expand state-based HAI prevention and surveillance efforts, and strengthen the public health workforce.

CMS Press Release, July 30, 2009

Red Flags Rule delayed, FTC expands education

The Federal Trade Commission (FTC) will further delay enforcement of the Red Flags Rule until November 1, 2009, and provide additional resources to assist small businesses, health care providers and other entities. The rule requires certain creditors (including health care providers) and financial institutions to implement programs that identify and respond to "red flags" that may indicate identity theft. The FTC's web site, www.ftc.gov/redflagrule, contains resources to educate entities about coverage and compliance, including an on-line compliance template that allows companies to create their own Identity Theft Prevention Program, articles geared for specific businesses and industries, and guidance manuals. The FTC will post a special link for small businesses and entities with a low risk of identity theft. With respect to small or low-risk businesses, the web site's Frequently Asked Questions section states that the FTC is unlikely to recommend an enforcement action if, for example, entities know their customers individually, or if they perform services near their customers' homes.

FTC Press Release, July 29, 2009

Jury OKs repatriation of uninsured illegal

A Florida jury has decided that a hospital's actions were reasonable and warranted when it chartered an airplane to deport a brain-damaged illegal immigrant against the will of his guardian. The patient was rendered bedridden and brain-damaged in a 2000 auto accident. The hospital continued to provide uncompensated care to the patient until 2003 because it could not find a skilled nursing facility that would accept the uninsured illegal immigrant. In 2003, after a Florida state court granted permission, the hospital chartered an air ambulance and returned the patient to Guatemala. The state court's decision was reversed in 2004, and the guardian sued the hospital for false imprisonment, seeking nearly \$1 million for the cost his continued care. Although the trial judge instructed the jury that the patient, as a matter of law, had been unlawfully detained and deprived of his liberty by virtue of his repatriation to Guatemala, the jury decided that the guardian failed to prove the final element of false imprisonment, that the hospital's actions were "unreasonable and unwarranted under the circumstances."

Montejo v. Martin Memorial Medical Center, Inc., Fla. Cir. Ct., July 28, 2009