
CLIENT NEWSLETTER

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DPH Provides Guidance on Serious Reportable Events

The Massachusetts Department of Public Health (“DPH”) recently sent a Circular Letter to hospital Chief Executive Officers and Risk Managers regarding the reporting of serious reportable events. The Circular Letter is meant to promote consistency among all Massachusetts hospitals in determining what constitutes a serious reportable event.

Pursuant to 105 C.M.R. 130.331, hospitals shall immediately report to DPH any of the following which occurs on premises covered by its license: (1) fire; (2) suicide; (3) serious criminal acts; (4) pending or actual strike action by its employees; and (5) serious physical injury to a patient resulting from an accident or unknown cause. Furthermore, a hospital shall file a written report with DPH regarding “any other serious incidents occurring on the premises covered by its license, and which seriously affect the health and safety of its patients”. The DPH Circular Letter includes a table from the National Quality Forum (“NQF”), which sets forth a list of serious reportable events. According to DPH, the NQF table is meant to be used as a guide by health care facilities in determining whether an incident qualifies as a serious reportable event.

In several instances in the NQF table, a “serious disability” is referred to as a serious reportable event. In order to assist hospitals in determining what meets the definition of a serious disability, the DPH Circular Letter includes a copy of the definition of serious disability utilized by the Minnesota Hospital Association. The Minnesota Hospital Association defines a serious disability by stating that a hospital’s clinical team of experts needs to determine the answer to each of the following questions:

1. Was there a physical or mental impairment that substantially limited one or more major life activities for the individual that lasted more than seven days or was still present at the time of discharge from the hospital?
2. Was there a loss of bodily function that lasted more than seven days or was still present at the time of discharge from the hospital?
3. Was there a loss of body part?

If a hospital's "clinical team" answers "yes" to any of these three questions, the outcome would be considered a serious disability by the Minnesota Hospital Association.

The Circular Letter also clarifies whether or not the preventability of an event has any bearing on whether it meets the definition of a serious reportable event. The Circular Letter notes that several Risk Managers have recently suggested that in instances where patients have fallen in spite of a properly executed care plan, the fall could not be classified as a serious reportable event because it was not preventable. DPH disagrees with this interpretation, stating in the Circular Letter that if an incident meets the definition of a serious reportable event as set forth in the NQF table, then the event must be reported to DPH as a serious reportable event.

The Circular Letter, including the NQF table, can be accessed on line at <http://www.mass.gov/dph>.

If you have any questions or concerns regarding the reporting of a serious reportable event, please do not hesitate to contact any of the attorneys at The Rogers Law Firm.

Attorney General's Office Issues Advisory Opinion on Independent Contractor Classification and Employment Laws

The Fair Labor Division of the Massachusetts Attorney General's Office ("AGO") recently issued an Advisory Opinion concerning the Massachusetts Independent Contractor Law, also known as the Massachusetts Misclassification Law (the "Law").¹ The Advisory Opinion provides important clarification and guidance for employers regarding the application of the Law, as well as possible penalties for violations thereunder. The AGO issued the Advisory Opinion to reiterate the importance of the correct classification of workers, asserting that the failure to comply with the Law has a profound impact on workers, the Commonwealth and its businesses.

The Advisory Opinion focuses on illegal employer practices, such as misclassification of workers, that may result in insurance fraud by depriving workers of many protections and benefits afforded employees. Entities that improperly classify workers also deprive the Commonwealth of tax revenue and place additional indirect costs onto the Commonwealth to compensate for employers' failure to provide health care coverage, workers' compensation benefits, and unemployment assistance. Finally, the Advisory Opinion notes the impact of misclassification on businesses, pointing to the competitive disadvantage imposed on those businesses which comply

¹ M.G.L. c. 149, § 148B.

with the Law. This imbalance results in compliant businesses subsidizing those that fail to pay the proper taxes and insurance premiums.

The Law

Historically, Massachusetts law followed a “totality of the relationship” test, weighing various factors to determine the existence of an employer/employee relationship. The factors included: the degree of control, the opportunity for profit and risk of loss, the employee’s investment in the business, the permanency of the relationship, the skill required and the degree to which the employee’s services were integral to the business. However, in 1990, the Legislature enacted the first version of the Law and established that despite classification under common law as an independent contractor, the worker could still be found to be an employee for purposes of the Law. Following subsequent amendments, the Law was transformed by broad changes including the expansion of its power to govern a wide range of industries beyond the area of public construction.

The current version of the Law sets forth a three-prong test for determining the classification of a worker as a class other than an employee. Each prong must be satisfied for such classification and the burden of proof lies with the employer. The failure to satisfy any one prong of the test is sufficient evidence to affirm that the worker in question is an employee.

Prong One. The first prong of the test requires that the individual be “free from control and direction in connection with the performance of the service, both under his contract for the performance of service and in fact.” The Massachusetts Appeals Court has held that this prong determines the degree of control retained by the employing entity, but does not require that the individual be entirely free from direction and control from outside forces.² The Advisory Opinion clarifies that an employment contract or job description asserting that an individual is free from such supervisory control is insufficient on its own to establish freedom of control.

Prong Two. The second prong maintains that the service the individual performs must be “outside the usual course of business of the employer.” To satisfy this requirement, courts have stated that the work performed must be distinctly independent from the business of the employer.³ If the individual’s work forms a continuous portion of the employer’s business, the second prong is not satisfied.⁴

The Advisory Opinion emphasizes that the AGO’s analysis of this prong will consider whether the service the individual performs is necessary to the business of the employing entity or merely incidental in determining whether the individual may be properly classified as other than an employee. The Advisory also underscores that no one prong of the test should be interpreted so broadly or construed to include all aspects of a business such that it renders prongs one and three unnecessary.⁵

Prong Three. The final prong of the test requires that the individual be “customarily engaged in an independently established trade, occupation, profession or business of the same nature as that involved in the service performed.” This final prong protects against use of the independent contractor status as cover for businesses to avoid the costs associated with employment. This step assesses whether the service provided could be viewed as an independent business in itself because

² *Commissioner of the Division of Unemployment Assistance v. Town Taxi of Cape Cod*, 68 Mass. App. Ct. 426 (2007).

³ *American Zurich v. Dept. of Industrial Accidents*, 2006 WL 2205085 (Mass. Super. 2006).

⁴ *Id.*

⁵ *Athol Daily News v. Board of Review of Div. of Employment and Training*, 439 Mass. 171 (2003).

the individual is capable of performing that service for anyone seeking that service, in contrast to a business relationship that requires the individual to rely solely on a single employer for the continuation of its service as a business. The outcome of this prong allows a determination of whether the worker is truly acting as an independent enterprise or rather an employee of the employing entity.

Non-contributing Factors. The Advisory Opinion interprets the Law to assess employment relationships based on these three prongs. Other factors, such as an employer’s failure to: withhold taxes; contribute to unemployment; or provide other essential benefits are not determining factors under the three-prong analysis. The Advisory Opinion interpretation also notes that an employer’s intention or view of the employment status as well as status of a worker as a sole proprietorship or partnership is irrelevant in the analysis of the Law.

Violations

The Advisory Opinion sets forth two acts that must occur to result in an employer violation of the Law: (1) the employer classifies or treats the individual other than as an employee although the worker does not meet each of the criteria in the three prong test; and, (2) in receiving services from the individual, the employer violates one or more of the following laws identified in the Law:

Wage and hour laws	M.G.L. c. 149
Minimum wage law	M.G.L. c. 151, §§ 1A, 1B, 19; 455 CMR 2.01
Overtime law	M.G.L. c. 151, §§ 1, 1A, 1B, 19
Law requiring employers to keep true and accurate payroll records and furnish them to the AGO upon request	M.G.L. c. 151, § 15
Provisions requiring employers to take and pay over withholding taxes on employee wages	M.G.L. c. 62B
Workers’ compensation provisions punishing knowing misclassification	M.G.L. c. 152, § 14

In response to violations of the Law, the statute provides the AGO with the authority to impose substantial civil and criminal penalties, or, in some circumstances, to preclude violators from public works contracts. The severity of the penalties is determined by the number and the nature of the violations. The Law also establishes liability for both business entities and individuals, including corporate officers and those who hold management authority over affected workers.

Enforcement

The Advisory Opinion provides businesses with general guidelines the AGO will use as a basis for enforcing the Law. The focus of the Law is specifically the misclassification of employees as independent contractors. Therefore, provided that all the individuals providing services for a business are classified as employees, are legitimately treated as employees of the entity and are

performing those services as an employee, then no misclassification issue exists. The AGO reiterates that determinations of whether the Law has been violated only begin if the individual is classified other than an employee.

The AGO acknowledges that there are some legitimate independent contractors and business-to-business relationships, and holds that such relationships will not be adversely affected by the Law if they meet the legal requirements. The key issue arises when businesses are created simply to avoid the Law. The AGO will enforce the Law against businesses that allow or contract with entities that exist for the purpose of avoiding the Law. Factors that will be evaluated in examining such situations include: whether the services of the alleged independent contractor are not actually available to entities beyond the contracting entity, even if they purport to be so; whether the business of the contracting entity is no different than the services performed by the alleged independent contractor; or whether the alleged independent contractor is only a business requested or required to be so by the contracting entity.

Although the Advisory Opinion notes that enforcement actions will be reviewed on a case-by-case basis, the AGO lists factors deemed to be strong indicators of misclassification that would merit further investigation and possible enforcement. Those factors include:

- Individuals providing services for an employer that are not reflected on the employer's business records;
- Individuals providing services who are paid "off the book", "under the table", in cash or provided no documents reflecting payment;
- Insufficient or no workers' compensation coverage exists;
- Individuals providing services are not provided 1099s or W-2s by any entity;
- The contracting entity provides equipment, tools and supplies to individuals or requires the purchase of such materials directly from the contracting entity; and
- Alleged independent contractors do not pay income taxes or employer contributions to the Division of Unemployment Assistance.

Conclusion

As stated in the Advisory Opinion, the AGO aims to prevent and remedy illegal business practices and abuse without disrupting legitimate business activity. Business employers that comply with the Law by proper classification of its business relationships will have no risk of penalty from the AGO while those entities which continue to misclassify business relationships will face civil and criminal penalties in an effort to restore the balance of the fair economic competition of the Commonwealth.

OCR Releases HIPAA Privacy Enforcement Data

The Office of Civil Rights (“OCR”) of the United States Department of Health and Human Services recently released compliance and enforcement data regarding the Privacy Rule of the Health Insurance Portability and Accountability Act (“HIPAA”). According to OCR, it has received a total of 32,595 HIPAA Privacy complaints since 2003. In calendar year 2007, the top five privacy issues investigated by OCR that resulted in corrective action included: impermissible uses and disclosures, safeguards, access, minimum necessary disclosures and notice.

OCR also provided the enforcement data for each state. Since the enactment of the HIPAA Privacy Rule in 2003, 67% of complaints related to covered entities in Massachusetts have been resolved by OCR after “intake and review”. Only 23% of the complaints in Massachusetts resulted in corrective action, while in 10% of the complaints OCR found “no violation”.

The OCR Enforcement Data can be accessed on line at <http://www.hhs.gov/ocr/privacy/enforcement/data>.

CMS Announces Bundled Payment Demonstration Project for Hospitals

The Centers for Medicare and Medicaid Services (“CMS”) recently announced the Acute Care Episode (“ACE”) demonstration project for hospitals to test the use of a bundled payment for both hospital and physician services for a select set of episodes of care to improve the quality of care delivered through Medicare Fee-For-Service. According to CMS, the purpose of the ACE Program is to use a global payment to better align the incentives for both types of providers, leading to better quality and greater efficiency in the care that is delivered.

Under the current Medicare reimbursement system for inpatient stays, CMS pays a hospital a single payment under the Inpatient Prospective Payment System (“IPPS”) for all care that the hospital furnishes to the patient during the patient’s stay. The physicians who are involved in the patient’s care during the inpatient stay are paid separately under the Medicare Fee Schedule for each service they perform. However, CMS believes that these separate payment systems can lead to conflicting incentives between the hospital and the physicians that may affect decisions about what care will be provided. Under the ACE Program, the hospital and physicians will receive a bundled payment that can be utilized as the hospital and physicians deem most appropriate.

CMS has chosen a select set of twenty-eight cardiac and nine orthopedic inpatient surgical services for the ACE Program. CMS is limiting the ACE Program to applicants from Texas, Oklahoma, New Mexico and Colorado. Nevertheless, CMS has indicated that if its program is successful, it will be expanded to other states.

Further information regarding the ACE Program can be found at <http://www.cms.hhs.gov>.

Massachusetts Medical Society Files Suit Over Physician Tiering Program

On May 21, 2008, the Massachusetts Medical Society (“MMS”) filed legal action seeking to “correct the wrongs” of the physician ranking program implemented by the Massachusetts Group Insurance Commission (“GIC”), the purchaser of health insurance for most Massachusetts state employees and retirees. The complaint, filed in Suffolk Superior Court, alleges that patients have been defrauded and harmed and physicians have been defamed by the GIC’s Clinical Performance Improvement initiative (“CPI”), a program that ranks (or “tiers”) individual physicians in one of three tiers, using various cost and quality measures. Under the CPI patients are charged higher co-payment fees for treatment by physicians assigned to the lower two tiers.

The complaint asks the court to either stop the tiering program, or require that the GIC adhere to specific standards in implementing the CPI, including transparency, fair notice, formal feedback and correction processes, meaningful physician involvement in the development of the CPI, demonstrate the program’s accuracy, validity and reliability, and submit their programs to an independent oversight authority. The MMS suit is one of several actions nationwide that have sought to rectify the alleged problems with physician tiering programs. The complaint states that on numerous occasions, physicians have been assigned to lower tiers because they were assigned to patients they did not treat, and procedures or care that they did not provide.

The plaintiffs are the Massachusetts Medical Society and five physicians: Joseph F. Adolph, M.D., a urologist who practices in Marlborough, Mass.; Linda Y. Buchwald, M.D., chief of neurology at Mount Auburn Hospital in Cambridge; Robert P. Nelken, M.D., a pediatrician in Andover; Susan L. Troyan, M.D., a surgeon who practices in Boston; and Peter T. Zacharia, M.D., an ophthalmologist who practices in Worcester. The defendants named in the complaint are the GIC, its executive director Dolores L. Mitchell, Tufts Health Plan and the UniCare Life Insurance Co.

The Rogers Law Firm will continue to monitor this suit and will provide updates accordingly.

IRS Releases Draft Instructions for Redesigned Form 990

On April 7, 2008 the Internal Revenue Service (“IRS”) released a draft of Instructions (“Instructions”) for the recently redesigned Form 990 (“Redesigned Form 990”), which organizations are required to file for the 2008 tax year (returns filed in 2009). The Instructions provide a general overview of the form and each schedule, an explanation of who must file that particular schedule, and line-by-line instructions to aid in answering each question on the form or schedule. According to the IRS, the Instructions also contain a number of new tools designed to make it easier for organizations to answer the questions and to promote more uniform reporting. These tools include a comprehensive glossary of terms; a sequencing list to help organizations determine the order in which to fill out parts of the form; a compensation table to help organizations determine how and where to report items of compensation; and many illustrative examples.

Background

On December 20, 2007, the IRS Exempt Organizations Division released the Redesigned Form 990, which is the informational return most charities and tax exempt organizations are required to file annually. The Instructions provide clarification and guidance to filing organizations that will complete the Redesigned Form 990 for the 2008 and subsequent tax years.

Summary

The Redesigned Form 990 consists of a core form, divided into eleven (11) “Parts”, and sixteen (16) “Schedules”. All organizations must complete the Core Form. The nature of an organization's activities determines which Schedules must be completed by that organization. In the Instructions, the IRS seeks to define terms and explain other concepts in both the Core Form and the Schedules that could be considered ambiguous. Further, the Instructions include examples to illustrate definitions and new requirements. This article provides a brief overview of both the corporate governance elements of Part VI of the Core Form as well as Schedule H, which pertains to “Hospitals”.

Corporate Governance

Independent Voting Members of the Governing Body. An organization’s governing body is the group of persons authorized under state law to make governance decisions on behalf of the organization and its shareholders or members, if applicable. The governing body is, generally speaking, the board of directors (sometimes referred to as the board of trustees) of a corporation or association, or the board of trustees of a trust (sometimes referred to simply as the trustees, or trustee, if only one trustee). An organization must list the number of independent voting members of the organization’s governing body as of the end of the organization’s tax year. A voting member will be considered independent if all of the following four criteria are met at all times during the organization’s tax year: (1) the member was not compensated as an officer or other employee of the organization or of a related organization (see Schedule R instructions) except for the religious exception discussed below; (2) the member did not receive total compensation or other payments exceeding \$10,000 for the year from the organization or from related organizations as an independent contractor, other than reimbursement of expenses or reasonable compensation for services provided in the capacity as a member of the governing body; (3) the member did not otherwise receive, directly or indirectly, material financial benefits from the organization or from a related organization; and (4) the member did not have a family member that received compensation or other material financial benefits from the organization or from a related organization.

Relationships among Officers, Directors, etc. The Redesigned Form 990 requires an organization to identify horizontal business and financial relationships among officers, directors, and key employees. The Instructions provide proposed definitions of “family relationship” and “business relationship”. The family of an individual includes only his or her spouse, ancestors, brothers and sisters (whether whole or half blood), children (whether natural or adopted), grandchildren, and spouses of brothers, sisters, children, and grandchildren. “Business relationship” includes various employment relationships, business arrangements, common ownership of business entities, and service on the board of the same business entity.

Changes to Organizational Documents. An organization must report to the IRS any significant changes to its organizing or enabling document by which it was created and to its rules

governing its affairs, commonly known as bylaws. The IRS requires that an organization report changes made since the prior Form 990 was filed, or that were not reported on any prior Form 990.

Material Diversion of Assets. The Redesigned Form 990 asks whether there has been a material diversion of assets, reflecting the IRS's concern with the increasing incidence of financial fraud committed against exempt organizations. The question does not inquire as to board action taken to prevent such fraud (*e.g.*, enhanced audit committee oversight). In the Instructions, the materiality threshold is set sufficiently high as to exclude some common types of cash misappropriation and non-extraordinary expense account abuse.

Documentation of Meetings and Actions. The Redesigned Form 990 asks whether the organization contemporaneously documents board and committee meetings. The Instructions provide proposed definitions of "documentation" and "contemporaneous". Documentation may include approved minutes, strings of e-mails, or similar writings that explain the action taken, when it was taken, and who made the decision. For this purpose, contemporaneous means by the later of (1) the next meeting of the governing body or committee (*e.g.*, approving the minutes of the prior meeting), or (2) 60 days after the date of the meeting or written action. If an organization's answer is "no," it should explain in Schedule O its practices or policies, if any, regarding documentation of meetings and written actions of its governing body and committees with authority to act on its behalf. These proposals are consistent with similar definitions as applicable to the satisfaction of the rebuttable presumption of reasonableness under the intermediate sanctions regulations.

Governing Body Review. The Redesigned Form 990 seeks to ascertain whether an exempt organization's governing board is required to review the Form 990 before filing. Details concerning the review (who conducted it, whether it was conducted before or after filing, the extent of the review) are to be described by each organization on Schedule O.

Conflicts Of Interest Policy. The Instructions provide substantial guidance on the Core Form questions regarding an exempt organization's conflict of interest policy. For example, the Instructions state that a "conflict of interest" arises when a person in a position of authority over an organization, such as an officer, director, or manager, may benefit financially from a decision he or she could make in such capacity, including indirect benefits such as to family members or businesses with which the person is closely associated. In addition, the Instructions state that "dualities of interest" are not considered conflicts unless they involve material financial interest or benefit to the person. A description is provided of the types of conflicts disclosures to be made on the annual questionnaire (*e.g.*, list of family members, substantial business or investment holdings, and other transactions or affiliations with businesses and other organizations). Also significant is the detail sought (for Schedule O) on conflicts enforcement practices, whether discovered before or after the transaction has occurred. This includes a description of the types of persons covered by the policy, the level at which the conflicts determination is made and at which actual conflicts are reviewed, as well as any restrictions imposed upon persons determined to have a conflict with respect to a particular transaction.

Executive Compensation. The Instructions confirm that the IRS is interested in determining whether an organization satisfied the rebuttable presumption of reasonableness for purposes of particular compensation decisions. The Core Form appears designed to inquire as to the basis by which comparability determinations were made.

Joint Ventures. The Redesigned Form 990 asks whether the organization invested or participated in a joint venture with a taxable entity during the year. In the Instructions,

additional clarity is provided with respect to the types of joint venture information which is being sought by the IRS. For example, the term “joint ventures” includes not only those formed as partnerships but also corporations. Information as to the purpose of the venture (*e.g.*, conduct an exempt purpose, an investment activity, or an unrelated trade or business) is to be provided. Certain types of joint ventures (*e.g.*, those with primarily passive investments) can be disregarded. Several examples of exempt purposes safeguards are also provided.

Interested Party Transactions. The Instructions include detailed information on reporting transactions with insiders (*i.e.*, transactions between the organization and its officers, directors, trustees and key employees, or their family members or the businesses in which they exercise significant ownership or control). Organizations must report transactions with insiders in excess of the \$10,000 per transaction threshold. Each payment falling under a separate contract or transaction is considered separately for purposes of applying this \$10,000 threshold. It is notable that transactions with partnerships, limited liability companies or professional corporations owned to any degree by officers, directors, trustees or key employees count as transactions with interested parties. In reporting transactions with insiders, an organization with more than 20 voting board members, and having an executive committee that has the power to act on behalf of the entire board, may disregard all current and former board members who are not current members of the executive committee, and who are not officers, key employees or one of the five highest paid employees. Loans between the organization and any executive or other disqualified person (under the intermediate sanctions rules) need not be disclosed if the loans are no longer in existence on the last day of the fiscal year to which the Redesigned Form 990 relates.

Schedule H: Hospitals

The Instructions illustrate that many hospitals and health care systems are unprepared at present to completely and accurately gather the information required to complete the full Schedule H when due in tax years starting in 2009. Hospitals should use Schedule H and its Instructions as a compliance tool for determining not only how the organization will be viewed to the general public when the full Schedule H is filed, but also to ensure that the current information-gathering systems are in place and that the hospital is able to accurately gather and collect the significant volume of data required to complete Schedule H.

Definition of Hospital. As previously announced by the IRS, the term “hospital” is defined as a “facility” that is licensed or certified in its state as a hospital, regardless of whether it is operated directly by the organization or indirectly through a disregarded entity or joint venture taxed as a partnership. The term “facility” is defined as a 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 by the filing organization or indirectly through a disregarded entity or joint venture. The inclusion of joint ventures in this definition will likely require such joint ventures to develop methods of collecting community benefit information as it relates to the joint venture. Pursuant to the Instructions, even if a hospital-licensed facility represents a small portion of a tax-exempt health care entity’s overall operations, and even if such entity is not classified as a hospital under Section 170(b)(1)(A)(iii) of the Internal Revenue Code, the health care entity must still file a Schedule H.

Bad Debt Expense Related to Charity Care. Schedule H, Part III requires hospitals to provide: (1) an “estimate” of the percentage of bad debt expense attributable to persons who qualify for financial assistance under its charity care policy; and (2) a rationale for what portion of bad debt expense the hospital believes should constitute community benefit. The Instructions state that hospitals may use any reasonable methodology to estimate this percentage, including record

reviews, assessment of charity care applications that were denied as a result of incomplete documentation, analysis of demographics or other analytical methods. If, upon review, the hospital determines that a patient would have been eligible for discounted care, but not free care, then the hospital may only include the costs of treating that patient less the amount of the discount in its estimate.

Joint Ventures and Management Companies. The requirement in Part IV of Schedule H that a hospital report interests in management companies and joint ventures is only applicable: (1) when directors, officers, key employees or medical staff physicians, in the aggregate, own 10 percent or more of the interests in such entities, and (2) the joint ventures or management companies (a) provide management services used by the organization in its provision of medical care, or (b) provide medical care, or own or provide real, tangible personal or intangible property used by the organization or by others to provide medical care. The instructions clarify that joint venture entities required to be reported by the hospital in this section include corporations.

Patient Education of Eligibility for Assistance. In Part VI of Schedule H, hospitals are required to describe how patients are informed as to the availability of financial assistance under government programs or under the hospital's charity care policy. A hospital may inform patients about eligibility for assistance, including: posting the policy in admission areas; emergency rooms and other areas in which eligible patients are likely to be present; providing a copy of the policy (or summary of the policy) and including financial assistance contact information as part of the intake or discharge process; and including such information in patient bills.

Community Building Activities. Schedule H requires hospitals to list the costs associated with "community building activities" and describe how those activities provide community benefit and promote the health of the community the hospital serves. The Instructions provide as an example that the recruitment costs of physicians and other health professionals to medical shortage areas or other areas designated as underserved may be included in this section. This implies that the costs associated with recruiting such health care professionals to areas that are not so designated should not be included in this section of the Schedule. However, IRS Rev. Rul. 97-21 states that the recruitment of physicians to a hospital need not be in a medical shortage area or area designated as underserved in order to be considered a charitable activity. Therefore, the Instructions appear to be in direct conflict with established IRS policy.

Worksheet 5 – Health Professionals Education. Hospitals are to use Worksheet 5 of Schedule H to calculate the net cost of providing education to health professionals, a recognized charitable benefit. The Instructions include a chart showing examples of education activities or programs that should and should not be reported. For example, providing education to nurses is considered a community benefit program only if the nurses are free to seek employment at any organization. If the nurses receiving the education are required to become employees of the hospital, the cost is not considered a community benefit by the IRS because such costs primarily benefit the hospital, not the community.

Conclusion

The above summary only provides a general overview of portions of the guidance contained in the Instructions. Links to the Instructions and the Redesigned Form 990 can be found on the IRS website for charities and nonprofits at <http://www.irs.gov/charities/index.html>. Should you have any questions regarding the Redesigned Form 990 or the Instructions, please do not hesitate to contact any of the attorneys at The Rogers Law Firm.

OIG Issues Advisory Opinion on Software Licensing Arrangement Between Physicians and Non-Profit Hospital Corporation

The Office of Inspector General (“OIG”) of the United States Department of Health and Human Services (“HHS”) issued an advisory opinion on May 29, 2008, in which it concluded that the implementation of custom software interfaces for use by hospitals to link with physicians and affiliates to order certain tests or procedures does not fall within the scope of a prohibited compensation arrangement under the Stark Law, 42 U.S.C., § 1395nn.

Background

Advisory Opinion 08-01 pertains to a request by a nonprofit corporation (“Requestor”) which owns and operates multiple hospitals to license a custom software interface (“Physician Interface”) for use by the physicians on its medical staffs and/or their physician practices (“Affiliates”) without any costs to the physicians (the “Proposed Arrangement”). The Requestor sought a ruling on whether the use of the Physician Interface would constitute a compensation arrangement within the definition set forth in § 1877(h)(1)(A) of the Social Security Act.

Under the Proposed Arrangement, the Requestor contracted with a third-party vendor to install a proprietary health care software information system (“System”), customized to the Requestor’s requirements, including a software interface engine that facilitates access by the custom Physician Interface. The contract provided that the vendor would supply software licenses to the Requestor, allowing the Requestor and the Affiliates to access the System. This arrangement allows medical staffs of the Requestor’s hospitals to view laboratory reports for the Requestor’s patients via a protected internet connection to the System. The Proposed Arrangement would expand this option to allow Affiliates to use the Physician Interface to order or communicate laboratory tests and procedures performed by the Requestor.

The questionable aspects of the Proposed Arrangement stem from the Requestor’s proposal to integrate the System with the individual electronic health records (“EHR”) systems used by the Affiliates in their practices. This integration requires custom development of an interface that can extract data from the System and transfer it to the Affiliates’ EHR systems. The final outcome would promote the secure transfer of patient data between the parties. Because of the varying EHR systems, several customized versions of the Physician Interface would be necessary as well as licensing arrangements for the Affiliates to use it. All of these expenses would be paid by the Requestor for the term of the license agreement.

The Proposed Arrangement would limit the Physician Interface for use only to order or communicate the results of tests and procedures and would be for tests or procedures furnished by the Requestor. The Affiliates have no access to apply or alter the Physician Interface, nor are they permitted to resell, transfer or assign licenses. No other items or services are provided to the affiliates in connection with the Proposed Arrangement.

OIG Analysis

In reviewing the Proposed Arrangement, the OIG assessed whether it qualified as an inappropriate compensation arrangement under the Stark Law. The Stark Law, or Physician Self-Referral Law, precludes a provider from referring Medicare/Medicaid beneficiaries for designated

health services to entities with which they, or members of their immediate family, have a direct or indirect financial relationship. The designated health services include: clinical laboratory services; physical therapy services; occupational therapy services; radiology services (including MRI, CAT Scans and ultrasound services); nuclear medicine services; radiation therapy services and supplies; durable medical equipment and supplies; parenteral and enteral nutrients, equipment and supplies; prosthetics, orthotics and prosthetic devices and supplies; home health services; outpatient prescription drugs; and inpatient and outpatient hospitalization services. The Stark Law defines a “financial relationship” as an ownership/investment interest in an entity or a direct or indirect compensation arrangement with an entity. A compensation arrangement is defined as including any arrangement involving any remuneration between a physician and an entity. Remuneration includes any remuneration, direct or indirect, overt or covert, in cash or in kind.

The OIG concluded that the Proposed Arrangement would not violate the Stark Law. The key factors the OIG cites in reaching its determination in this regard are the limitations the Proposed Arrangement places on the use of the Physician Interface which include: (1) may only be used to order or communicate the results of tests and procedures furnished by the Requestor; (2) cannot be modified to perform an alternate function; and (3) cannot be resold, transferred or assigned by an affiliate. Based on these restrictions, OIG concluded that the Proposed Arrangement does not result in a prohibited compensation arrangement.

Conclusion

The OIG emphasizes that this opinion is only applicable to the specific Proposed Arrangement from the Requestor. In addition, OIG asserts no opinion on whether the use of the Physician Interface constitutes any other form of prohibited remuneration under the Federal anti-kickback statute, the False Claims Act, or other Federal, State, or local statutes and governance.

If you have any questions regarding the OIG’s Advisory Opinion, please do not hesitate to contact any of the attorneys at The Rogers Law Firm.

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