

# Health Law ADVISORY

*Current legal insights for health care executives*

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## *New IRS Form 990 – Top Ten Things Hospitals Need to Know*

The IRS released the final draft of the revised Form 990 on December 20, 2007. The earlier draft released in June 2007 had sparked much concern over the nature and content of questions being asked by the IRS. The final draft addressed many of these concerns and indicates that the revisions were driven by the desire to ensure the core form appropriately collects information for the various types and sizes of organizations required to complete the form, and to address the concerns expressed by public comments.

We have evaluated the revised Form and believe that there are ten key things that hospitals should know about it.

1. The overall structure, core forms and schedules remain intact. This will require a substantial change in how hospitals and other organizations approach the completion of the Form 990. It will also provide much more information than now available, and all of this will facilitate the IRS goals of more transparency and greater ability to make comparisons between organizations.
2. Schedule O now exists. This new Schedule allows for optional or required supplemental responses to several questions, as well as the opportunity for the organization to add further comments about any aspect of its operation and its continued exemption. Without this, the e-filing requirements would have precluded such additional information.
3. There is no delay except that parts of certain Schedules are optional for 2008. Only Part I of Schedule K-Bonds is required for 2008; the rest of Schedule K is optional for 2008 but required for 2009. Only Part V of Schedule H-Hospitals is required for 2008; the rest of Schedule H is optional for 2008 but required for 2009. Many commenters urged the IRS to delay all or parts of the form for one or more years. In the end, the IRS agreed that the new information required on Schedules H and K should be delayed by a year so that organizations can better adjust their processes to gather the necessary information.

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4. Good Governance Principles remain (despite concern that they become standards for exemption). Several commenters expressed concern with the breadth of good governance questions and that these questions would become part of the requirements for exemption. The IRS modified some of the questions, but did not change its approach. While these questions are not strictly requirements for continued exemption, organizations should expect the IRS to approach these questions as reflecting the sort of practices that are expected of well-managed exempt organizations.

5. Instructions are not out yet. Knowing how to respond to many of the questions will require reference to instructions. There are not yet any instructions, and thus no ability to evaluate this. An example is the question as to the number of “independent directors”. There is as yet no definition of this term.

6. Charity care is still at cost, and Medicare shortfalls/bad debt expense are still excluded. However, Medicare shortfalls and bad debt expense can now be reported elsewhere along with why you think they should count.

7. Community benefit is back. The revised form reflects IRS consideration of community benefit and community building activities. A new section has been added dealing with community building activities. Another question allows the hospital to describe community benefit in traditional terms of open medical staff, research, emergency room, etc.

8. The first filing of the new Form 990

will require several policy and practice descriptions that need to be carefully drafted and evaluated. These questions will require careful and thoughtful responses that will be guides for future filings. Examples include various questions that ask for descriptions of policies and practices.

9. Questions about Board review of 990 prior to filing have been modified. Previously, the draft suggested that a good governance practice would be whether the Board reviewed the full 990 in advance of its filing. Now, the question asks about the process for review of the 990 prior to its filing, and whether the 990 was provided to the governing body before its filing.

10. It's still much more than a financial report. The final Form 990 completes a transition that has been occurring over the last several years. Where the 990 used to be a financial report, it is now clearly much broader than that. Organizations that treat the 990 as purely a tax filing will miss the point and subject themselves to future inquiries and audits.

*The first filing of the new Form 990 will require several policy and practice descriptions that need to be carefully drafted and evaluated.*

**John R. Holdenried**

# *CMS Announces Partial Moratorium for the Anti- Markup Rule*

Providers and suppliers have spent an enormous amount of time and effort grappling with the expansive changes CMS made to the anti-markup rule<sup>1</sup> as part of the 2008 Physician Fee Schedule. Faced with a very high volume of comment and substantial criticism, and perhaps realizing that the rule carried many unintended consequences, CMS announced on January 3, 2008 a one year Moratorium delaying the effectiveness of certain portions of rule until January 1, 2009.

Gone is the provision expanding the rule to cover the *professional component* of diagnostic tests. Gone too is the expansion to cover any component performed *outside of the physician's office*, even if performed by the group's own employees and physicians (with one exception discussed below).

That is the good news. However, other somewhat expanded provisions do survive and are effective. They are:

- The term "outside supplier" is now defined. It includes anyone who is not an *employee* and who does not furnish the test component under a reassignment that meets certain conditions. Very few categories are

eligible to reassign under Medicare. Thus, many personnel furnished per click or otherwise to perform the TC of a test in a physician's office will be "outside suppliers." This increases the risk that, based on payment and other terms, the test will be viewed as purchased from an outside supplier and therefore a purchased diagnostic test.

- A physician or supplier purchasing a diagnostic test can bill no more than the "net charge" paid for the test. The rule now requires that the "net charge" be determined without regard to any space or equipment rental imposed by the billing physician or supplier on the performing supplier.

There is one other change that is not subject to the Moratorium. Anatomic pathology diagnostic testing services furnished in space that is used by the billing physician or group as a "centralized building" (for Stark purposes) is subject to the anti-markup rule, just because of where is performed. A group that purports to perform anatomic pathology diagnostic testing services for itself, but in a location other than its clinic where it sees patients, needs to carefully check to see if the tests are now subject to the rule.

**Alex M. (Kelly) Clarke**

<sup>1</sup> 42 C.F.R. § 414.50.

*Providers and suppliers have spent an enormous amount of time and effort grappling with the expansive changes CMS made to the anti-markup rule...*

# *Don't Thumb Your Nose at Thumb Drives*

They are small, they are convenient, and they are a serious risk. Universal Serial Bus “USB” drives (a/k/a thumb drives, memory sticks, zip drives) are often smaller than a stick of gum but commonly have data capacities of 4GB or more. They plug easily into the USB port of a computer and are often undetected. They pose a serious risk as a way for data to leave an otherwise secure facility or for malware to be introduced into a secure facility.

For example, a 4GB USB drive could easily contain over 2 million pages of text information. It could also easily contain protected health information (“PHI”) on thousands of patients. And its not just USB drives that pose such a risk. Apple iPods and MP3 players which can be used to transport sensitive information have enormous capacities, commonly reaching 80 GB or more.

HIPAA regulations (§164.310(a)(1) and §164.310(d)(1)) mandate that facilities covered by the security rules implement “policies and procedures that govern the receipt and removal of hardware and electronic media that contain electronic protected health information into and out of a facility, and the movement of these items within the facility.”

In order to comply with this requirement and to keep your security program current regarding evolving risks, we recommend that you evaluate the risks and vulnerabilities posed by such portable

devices. Some of the best practices that you may want to consider incorporating in your facility’s security policies are:

1. Any portable device carrying PHI must protect the data with a method of data encryption.
2. Access to data on portable devices must be protected by the use of strong authentication measures such as strong passwords and automatic locking of the device after a limited number of failed password attempts.
3. All portable devices containing PHI (whether personal or facility-owned) must be registered with the facility and comply with all security directives.
4. Wireless data transmission to and from the portable device, including syncing, must be done via an encrypted connection.
5. Any portable devices should be adequately safeguarded from theft or loss.
6. All portable devices will be marked as confidential and indicate method of return if found. Any misplaced portable device must be immediately reported.
7. All portable devices are subject to the facility’s workstation security guidelines, including public display restrictions, backup requirements, and automatic locking after a period of inactivity.

Finally, education of end users regarding the risks and responsibilities associated with these portable devices is absolutely critical to the success of your security program.

**James E. O’Connor**  
**Technology & Intellectual Property**  
**Practice Group**

*[USB drives] pose a serious risk as a way for data to leave an otherwise secure facility...*

# Upcoming Speaking Engagements

March 6, 2008 Current Legal Issues for  
Critical Access Hospitals, Iowa Hospital  
Association, John Holdenried and Vickie  
Brady

## Congratulations!

To Andy and Carla Kloeckner on the birth  
of their son, Andrew Dale Kloeckner, Jr.,  
known as “Drew,” on January 8, 2008.

Drew is doing very well and his parents are  
hanging in there.

### Questions? Ideas?

We welcome your questions, ideas and sug-  
gestions.

E-mail [jknutson@bairdholm.com](mailto:jknutson@bairdholm.com) and help  
make the Advisory interactive!

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