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The Quarterly

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IRS TAKES A HARDER LOOK AT "CHARITY CARE" COMPONENT OF TAX EXEMPT HEALTH CARE PROVIDERS

By Steven T. Hanford, Esq.

The Office of Chief Counsel of the Internal Revenue Service has issued a Field Service Advice letter dated February 5, 2001, in which it advises IRS field offices that a tax exempt hospital's stated policies to provide health care services to the indigent may not satisfy the charity care requirement of the "operational" test under Treasury Regulation § 1.501(c)(3)-1(c), unless the hospital can show that its policies actually result in "the delivery of significant health care services to the indigent." The same standards would apply to a tax-exempt provider of long term care to the elderly.

A Field Service Advice is intended as guidance for the field offices, and is not binding in examinations, appeals or cases in which the IRS is a party. It is a clear indication, however, that the "operational" aspects of the provision of charity care will be a strong focus in any examination of a facility's tax exempt status, and that the IRS has determined that facilities have not been adequately documenting this part of their mission. There are, however, several simple, straightforward steps that can help your tax-exempt facility survive a visit from a revenue agent.

Section 501(a) of the Internal Revenue Code provides that entities organized and operated exclusively for charitable purposes are exempt from federal income tax. The Treasury Regulations implementing the Code require an entity to meet both an "organizational" test and an "operational" test in order to be considered charitable and, therefore, tax exempt.

The "organizational" test is satisfied if the entity is organized on a not-for-profit basis, and completes the appropriate documentation. For example, in the case of a non-profit corporation, its articles of incorporation must provide that its assets will only be used for charitable purposes and, upon the liquidation of the corporation and sale of those assets, any proceeds will continue to be used for charitable purposes, and no portion will inure to the benefit of any private individual or entity.

The "operational" test requires that the entity actually operate to further a charitable purpose. The promotion of health has been recognized as a charitable purpose under Section 501(c)(3), but a hospital or other health care organization does not automatically qualify for exemption just because it promotes health. The provider's services must also produce a quantifiable benefit to the community. The Field Service Advice references courts decisions in which it was held that the provider must be able to demonstrate that it actually provides free or subsidized care to the indigent.

Demonstrating the delivery of charity care can be complicated for long term care providers, in that most indigent residents qualify for, and receive, some form of government assistance. A telephone call to Donald Spellman, of the Office of Chief Counsel in Washington, yielded the following practical advice for any tax-exempt facility wishing to pass the "operational" test:

1. All facility policies regarding the provision of care to the indigent should be clear and should be made available to all staff members and to community served by the facility. Confusing policies governing the provision of charity care, or policies that are not known to the community being served by the facility, have been held to be ineffective in promoting the charitable purposes of tax-exempt organizations.

2. The facility must be able to document that it has actually admitted and provided services to a significant portion of patients or residents who seek those services, regardless of their ability to pay. The number served must be "significant" — the IRS has challenged the tax exemption of facilities that accept a minimal number of "token"

charity cases while referring the rest to other providers.

3. A facility must document all cases in which it has provided services to the indigent for free or at a significantly reduced rate. A single-line write-off for uncompensated care should be supplemented or replaced by schedules showing the type of care provided, the costs incurred and the fees, if any, collected for the services.

4. A long term care facility with a significant Medical Assistance census should be able to demonstrate the extent to which the actual per diem cost of care exceeds the reimbursement rate, and the extent to which the facility provides services for free or at reduced rates to its MA residents.

Spellman explained that the tax exemption provisions of the Internal Revenue Code were drafted prior to the widespread introduction of medical assistance and other forms of subsidized care for the indigent, and so do not specifically address the incorporation of government subsidies into charity care. However, the IRS recognizes that government subsidies often fail to cover the full cost of providing services to the indigent, and charity care will often include a facility providing care to all who need it, regardless of whether the individual, or the government, can pay the full cost of the services provided.

In summing up a tax-exempt facility's obligations under the Treasury Regulations, Spellman noted that the 501(c)(3) exemption from federal income taxes confers a substantial benefit, intended to help a charitable institution fulfill its mission; the IRS believes it is not unreasonable to expect that an institution be able to document and demonstrate that is has used its exempt status to benefit the community most in need of charitable services.

For more information, or for a copy of the Field Service Advice, please contact Steve Hanford at 717-233-4101 or at SteveH@capozziassociates.com.

DPW RELEASES REVISED DRAFT REGULATIONS FOR MOVABLE EQUIPMENT REIMBURSEMENT

By Daniel K. Natirboff, Esq.

The Department of Public Welfare (DPW) released its latest draft of its proposed revised Movable Equipment regulations for nursing facility reimbursement under the Medical Assistance ("MA") program on March 16, 2001. The Department received numerous comments on the proposed regulations and has provided responses to many of the comments. The proposed regulations remain substantially the same with the exception of some changes to the language for purposes of consistency. Movable equipment reimbursement has been the subject of controversy and numerous appeals since the implementation of DPW's current case-mix reimbursement system. Among the issues raised by providers in appeals were: (1) DPW's use of outdated appraisals and a "model" to update the appraised value of movable equipment resulting in deflated valuation; (2) DPW's application of the "moratorium" regulations to disallow movable equipment on a pro-rata basis proportionate to the number of beds in the facility constructed after the 1982 moratorium; and (3) DPW's reclassification of certain on-going stocking expense (i.e. dishes, linen, kitchen supplies, etc.) from operating costs to capital reimbursed as part of "fair rental value."

In response to public comment and litigation surrounding the movable equipment issue, the Department has endeavored to overhaul its method for reimbursing movable equipment. The Department's proposed regulations will be effective for cost report periods beginning on or after January 1, 2001. Providers will not see these changes affect their reimbursement until the issuance of Case-Mix Rates effective July 1, 2003 (Year 9) at earliest. No provider will be reimbursed under the new system until it has an audited cost report in the database for a fiscal period beginning on or after January 1, 2001 and all providers will continue to be reimbursed under the current system until that time. The new Capital Cost Component of a provider's Case-Mix Rate will include the fair rental value of fixed equipment as in the current system limited by $26,000 per bed and, for the first time, "the audited acquisition cost of major movable property" from the most recent audited MA-11 in the database. (See §1187.51(4)(ii) in the draft regulations). Accordingly major movable property newly acquired will be reimbursed after it is reported on the facility's MA-11 and that cost report is audited and used by DPW in the case mix database. The provider will receive the "acquisition costs" of the equipment and not be limited to its "fair rental value."

"Major Movable property" is defined as "any movable property that has an acquisition cost of $500 or more." (See §1187.2 in the draft regulations). Minor Movable property with an acquisition cost under $500 including the aforementioned dishes, linen etc. will be reimbursed as part of the facility's operating costs. "Movable property" is defined generally as "any tangible property that is not fixed property or a supply." "Fixed property" is defined as equipment affixed to the building or connected to a utility by a "direct hook-up." The proposed regulations specifically include "heating, ventilation and air-conditioning equipment."

The proposed regulations seem to address many of the concerns raised by providers. Movable equipment will either be reimbursed as operating costs for minor property or reimbursed following its acquisition in the case of major movable property without regard to the "moratorium." However, even with these favorable revisions, there still remain imperfections in the system that may result in further controversy. Specifically, once providers transition to the new system and have a cost report audited and in the database for FYE: 12/31/01 and thereafter, they will only receive reimbursement for movable equipment

acquired during that cost reporting year and receive nothing for equipment acquired prior to that fiscal year either as acquisition costs or fair rental value. Another major area of concern will be the definition of "Fixed Property." The same disputes that providers raised with respect to reclassification of movable equipment as fixed under the cost based system will be relevant here given the continuing limitation of Fixed Property" to $26,000 per bed.

DPW anticipates receiving internal approval for the draft regulations for presentation to the Independent Regulatory Review Commission ("IRRC") in late April.

RULE FOR ALLOCATION OF WORKMEN'S COMPENSATION COSTS STILL AWAITING FINAL DECISION IN MEDICARE COST-BASED APPEALS IN WHICH FISCAL INTERMEDIARIES CONTINUE TO CONTEST PRRB'S "LONGWOOD" DECISION

Louis J. Capozzi, Jr., Esquire

Medicare cost-reimbursed providers, including Skilled Nursing Facilities (SNFs), won a significant victory in 1999 when the Provider Reimbursement Review Board (PRRB) decided in *Longwood Management Corporation Group Appeal, Case No. 97-0354G (Decision No. 99-D34)*, that Workmen's Compensation costs were properly included in Administrative and General expenses and allocated over <u>all</u> allowable costs. Nevertheless, Medicare Fiscal Intermediaries (FIs), including Veritus Medicare Services, have continued to reclassify these insurance costs as an employee benefit cost allocated according to employee salaries, reclassifications that were reversed in *Longwood*. While the major impact of this issue is on provider cost reports that directly affect reimbursement (e.g., SNF cost reports for pre-PPS periods), the issue affects cost reports filed under PPS regulations and also the Medicare Part B offsets made pursuant to 55 Pa. Code § 1187.72 under Pennsylvania's Case-Mix cost finding system.

The FIs, in position papers filed with the PRRB after the *Longwood* decision was issued (January 26, 1999), have called for the PRRB to abandon the reasoning in *Longwood* and permit allocation to Workmen's Compensation costs based on employee salaries alone, even though the HCFA Administrator determined not to reconsider the PRRB's decision in *Longwood*. Our Firm is representing a number of providers in appeals presently pending before the PRRB contesting the FIs' continuing reclassification of Workmen's Compensation costs from Administrative and General for Medicare providers throughout the country. Because the issue continues to have national impact, Counsel from HCFA and the Blue Cross/Blue Shield Association in Chicago have been meeting to discuss how to deal with the issue in these pending matters. Attempts to resolve this issue through the use of the PRRB's new mediation procedures have been rejected.

The legal arguments of the FIs in opposition to *Longwood* are based on some incorrect premises, at least about Pennsylvania Workmen's Compensation law. The contention of the FI in *Longwood* that, because the "contracted personnel are covered for workmen's compensation purposes by their employers," "there is no reason for the Providers to cover contracted personnel for work-related injuries because any such insurance requirement would already have been met by the contractors' liability insurance," is not correct under Pennsylvania law, since whether another entity may also include the injured person in their Workmen's Compensation coverage does not control which entity is responsible for a claim. <u>See</u>: *JFC Temps, Inc. v. WCAB (Lindsay and G&B Packing)*, 545 Pa. 149, 680 A.2d 862 (1996); *Gailey v. SWIF*, 286 Pa. 311, 133 A. 498 (1926); *Rolick v. Collins Pine Co.*, 925 F.2d 661, 665 (3rd Cir. 1991). As a result, employers may be liable for Workmen's Compensation claims resulting from injuries to persons to whom they do not pay a salary or other fringe benefits, but obtain through a contract from another source.

The cost of Workmen's Compensation insurance, therefore, protects the employer not only from separate liability for claims filed by employees who are paid on a salary basis, but also from separate liability for claims that may be filed by persons who may be deemed to be qualified for such benefits allocated to that employer because the work involved benefited that employer and was subject to the control of that employer. A cost center that includes no salaried employees still benefits from Workmen's Compensation insurance, because that insurance protects the employer from separate liability for claims by other persons (such as contract workers) whose work that employer benefits from and controls. The allocation of the cost based on salaries alone, according to the Fis' reclassification, then, is contrary to the requirements of 42 U.S.C. § 1395x(v)(1)(A) and 42 CFR § 413.5(a), which preclude allocations that result in costs related to Medicare patients being borne by others.

Federal and State laws require a Medicare-participating SNF to control the performance of the work provided by outside sources as well as its own employees. Medicare participation requirements establish that the SNF must assume responsibility for assuring that services furnished by outside resources meet professional standards and principles that apply to professionals providing services in the facility (42 CFR § 483.75(h)(2)) and that the SNF operates and provides services

in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility (42 U.S.C. § 1395i-3(d)(4)(A); 42 CFR § 483.75(b)). State licensure regulations (28 Pa. Code §§ 201.14(a) and 201.21(a)) require Pennsylvania nursing facilities to assure that all services provided by outside resources meet applicable licensing and certification requirements and that the operation of the facility is in compliance with regulatory standards.

The *Longwood* decision is consistent with Pennsylvania's expansive employer liability protection under the Workmen's Compensation Code and Medicare participation requirements for employer control of the performance of services provided to Medicare beneficiaries. Our Firm has provided Counsel for the Blue Cross/Blue Shield Association with our analysis and is advised that they are currently reviewing whether Pennsylvania Workmen's Compensation law requires that this issue finally be settled in favor of Pennsylvania Medicare providers following the reasoning in *Longwood.*

Please let us know if you have any questions regarding whether your facility can benefit from our analysis of whether an appeal can be filed with the PRRB even where Workmen's Compensation costs are not properly claimed in A&G.

On April 17, 2001 HCFA posted the updated list of MDS Automation Coordinators and RAI Coordinators for each state. All states are listed on HCFA's website under MDS 2.0 Technical Information, "What's New" located at http://www.hcfa.gov/medcaid/mds20/default.htm

MDS Automation Coordinator:

Pennsylvania — Bonnie L. Rose (717) 772-2570
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New Jersey — Pamela Z. Gendlek (609) 633-8980
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RAI Coordinator:

Pennsylvania — Susan Getgen (717) 878-1816
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New Jersey — Beth Bell RN (609) 633-8981
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CALENDAR OF EVENTS

August 28-29, 2001

Training Seminar: Corporate Compliance Training for Long Term Care Facilities in Pennsylvania, presented in Erie, Pennsylvania

September 28, 2001

Seminar at Slippery Rock University - "Government's Role in Health Care Policy, Regulation and Reimbursement," by Elizabeth S. Antoun, R.N., Esquire and Bruce G. Baron, J.D., Research Coordinator

October, 2001

PALA Annual Meeting

Louis J. Capozzi, Jr., Esquire and Michael A. Hynum, Esquire will be speaking on guardianships, as well as other regulatory and compliance issues.

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