The Good, the Bad, and the Ugly: Addressing Tax and Compliance Issues Posed by Electronic Health Systems

Recent Developments Highlight the Complexity of Tax and Compliance Consequences

Ralph Levy, Jr.

A significant development among hospitals, physicians, and other health care providers is the adoption and implementation of electronic health record (EHR) systems in part based on financial incentives to do so under the American Recovery and Reinvestment Act (ARRA). Much has already been written on the requirements such as the meaningful use requirements that eligible professionals must meet to be eligible for incentive payments. For hospitals, physicians, and other types of health care providers ("eligible providers") that began participation in the program by using EHR systems before 2013, ARRA authorized the Centers for Medicare & Medicaid Services (CMS) to pay up to $44,000 per eligible professional over a five-year period. Each eligible provider must demonstrate "meaningful use" to receive payments under this program.

CMS recently announced that payments in excess of $13.7 billion have been made under this program to just under half of the eligible health care professionals (approximately 256,000 out of 527,000 eligible health care professionals) and to just under 77 percent of the hospitals that are eligible to participate in the program (3,858 hospitals out of 5,011 eligible hospitals).

CMS has expressed its concerns that increased adoption and implementation of EHR systems might even have an unintended consequence of increased billings by providers to CMS for services rendered. Significantly less attention, however, has been devoted to the compliance-related aspects of EHR systems — particularly where health care professionals (particularly physicians) have received EHR systems that have been partially donated

Ralph Levy, Jr. is of counsel in the Nashville, Tenn. office of Dickinson Wright PLLC. He can be reached at 615/620-1733 or by email at rlevy@dickinsonwright.com. Dickinson Wright PLLC is a full-service law firm with over 350 attorneys with offices in Michigan, Tennessee, Arizona, Nevada, Ohio, Washington, D.C., and Toronto, Ontario.

to the professionals (typically by hospitals or outpatient providers with which the professionals have referral relationships). Even less attention has been given to the tax consequences of the partial donation (*i.e.*, sale at below cost) of EHR systems.

This article will address recent developments in the compliance-related aspects of donated EHR systems (where physicians receive donated systems) and the federal income tax consequences of payments made by CMS under the ARRA to physicians and hospitals as an incentive to adopt EHR systems (where physicians or hospitals paid for the systems). These are what I call the Good, the Bad, and the Ugly Compliance-Related and Tax Issues posed by EHR systems.

The Good

Likely Extension of Federal Self-Referral and Anti-Kickback "Exemptions" as to Donated EHR Systems Beyond December 31, 2013

Under guidelines contained in regulations promulgated by CMS (as to the federal physician self-referral law, generally called the "Stark law") and by the Office of Inspector General of the U.S. Department of Health and Human Services (OIG) (as to the federal anti-kickback statute), a donor is permitted to "donate" EHR technology and services to persons who are in a position to refer business to the donor. These "exemptions" (really an exemption under the Stark law and a safe harbor under the anti-kickback law, both of which will be referred to in this article collectively as the "EHR rules") are scheduled to expire on December 31, 2013. The EHR rules, a detailed discussion of which is outside the scope of this article, impose several conditions to the regulatory exemption as to donated EHR systems. For example, the recipient must pay at least 15 percent of the donor's cost of the EHR technology and services *before* the donee receives such items. (Thus, there can be no free ride, even as to donated items).

If the conditions in the EHR rules are met, a hospital that has a referral relationship with a physician group could "donate" an EHR system to the physician group at a deeply discounted price (*i.e.*, 15 percent of the hospital's cost for the system).

In tax parlance, since the physician group must pay at least 15 percent of the donor-hospital's cost for the EHR systems, this would be referred to as a "part sale-part gift." (This term is generally used by tax practitioners to characterize transactions in which property is transferred at below fair market value.) Why would a hospital be interested in making a partial donation (a part sale-part gift) to a physician group? If the hospital has a referral relationship with the physician group, the hospital might believe that it could benefit from the arrangement by enabling the hospital to improve the quality of care provided to its patients, particularly if the EHR system that is donated to the physician group uses the same information platform as the EHR system that is utilized by the hospital.

For example, through decreased readmissions of hospitalized patients after their discharge, a hospital might become eligible for incentive payments under a program recently initiated by CMS that pays hospitals additional "bonuses" if the hospital reduces its post-discharge readmission rate below certain specified targets. Moreover, CMS is exploring new payment models (*e.g.*, its Bundled Payments for Care Improvement Initiative) that also would provide financial incentives to reduce hospital readmissions. If this occurs, a "win-win-win" takes place.

First, the physician group saves significant money by taking advantage of the deeply discounted cost to obtain and implement the EHR system. Next, the hospital's revenues increase due to its receipt of quality improvement payments from CMS under the post-discharge readmission incentive payment program. Finally, CMS benefits since the per patient health care cost decreases if a patient does not have to be readmitted to the hospital.

This is the logic that was adopted by CMS and OIG in 2006 when they promul-

gated the EHR rules. These agencies selected a 2013 expiration date for the exemptions since they felt that after December 31, 2013, the need for EHR donations would have decreased; however, based on unanticipated delays in the adoption of EHR systems by health care providers on a universal basis, CMS and the OIG believe that the sunset date for the expiring EHR rules needs to be extended.

In anticipation of an extension of the sunsetting EHR rules, on April 10, 2013, CMS and OIG published proposed rules (the "EHR rules proposal") that would extend (and slightly modify) the protections of the EHR rules from December 31, 2013 until December 31, 2016. According to OIG and CMS, the rationale for extending the scheduled sunset for the "exemptions" is that "while the industry has made great progress, the use of such technology has not been universally adopted nationwide, and continued electronic health record technology adoption remains an important Departmental goal."

The governmental agencies selected the end of 2016 as the extended expiration date since that year is the last one in which eligible providers can receive from Medicare an incentive payment under the ARRA. The comment period to the EHR rules proposal expired on June 7, 2013. It is noteworthy that the EHR rules proposal indicates that CMS and the OIG also may consider a later sunset date (such as December 31, 2021). Comments were sought as to whether an extension beyond 2016 should be adopted when the final rule is issued that extends the EHR rules.

During the comment period, the American Hospital Association (AHA) sent a letter to the Inspector General that encouraged the agency to make the regulatory protections permanent rather than temporary so that they expire on a specified date. In addition, AHA urged against any further tightening of the existing regulatory requirements that are contained in the EHR rules.

Although a detailed discussion of the EHR rules proposal is beyond the scope of this article, it differs in certain respects from the EHR rules now scheduled to expire in December. For example, the EHR rules proposal does not require that the donated EHR system contain electronic prescribing capability.

The release of the EHR rules proposal and its likely adoption prior to the scheduled December 31, 2013 sunset of the current EHR rules is certainly "good news" to hospitals, physicians, and other health care providers that wish to consider the donation of EHR systems during the 2014-2016 time period.

The Bad

Restrictions that May Prevent or Limit Donations of EHR Systems under State Laws and Possible Future Regulations

Although it appears likely that even after 2013, CMS and OIG will allow for the donation of EHR systems under federal law, state laws may limit or prevent donations of EHR systems to physicians and other health care providers. Laws of this type, which preempt federal law, will continue to limit the use of donated EHR systems.

One example of such a state law prohibition on donated EHR systems is illustrated by a legal opinion issued in March 2013 by the Tennessee Attorney General. Under Tennessee law, clinical laboratories are prohibited from soliciting the referral of specimens for testing. This legal opinion concluded that this statute will prevent a clinical laboratory from making a monetary donation to a physician to help pay for EHR software as part of a referral arrangement between the laboratory and the physician. The statutory prohibition on the solicitation of specimen referrals will prohibit the payment by a clinical laboratory for EHR systems utilized by physicians as part of a new or continuing referral arrangement with the laboratory.

Although the Tennessee statute referred to in the March 2013 legal opinion was limited to the donations of EHR systems by clinical laboratories with which the physician has a referral relationship, statutes or regulations in other states may prohib-

it or limit donations of EHR technology or EHR systems by hospitals, insurers, or other types of health care providers. Hospitals, insurers, and other health care providers should carefully review all applicable state laws that govern their operations *before they donate* EHR systems and other EHR technology to physicians or other health care professionals or providers. By the same token, *before accepting donations* of such items, physicians and other health care professionals also should confirm that applicable state laws will not limit or affect their ability to accept these donations.

The Tennessee legal opinion and statute also point out one additional potential area of caution as to federal law — the potential for future regulatory limitations as to the donations of EHR systems by ancillary providers of health care services or supplies such as clinical laboratories. In the EHR proposed rule, CMS and OIG indicated that they had received complaints about EHR donations made by laboratories. As a result, in the EHR rules proposal, CMS and the OIG invited comments as to whether the final rule that extends the expiration date of the EHR rules should exclude "high risk donors" such as laboratories, durable medical equipment suppliers, and home health agencies. Be on the lookout for future developments in this area (particularly in the final version of the EHR rules proposal) that could impact the donations of EHR systems by donors of this type starting in 2014.

In conclusion, the "bad news" as to donations of EHR systems is that although such donations likely will continue to be permitted after 2013, applicable state law may limit or prevent altogether the donation of EHR systems or other EHR technology. In addition, the types of permissible donors may be narrowed in the future under federal law or regulations to eliminate or limit such donations by ancillary providers such as clinical laboratories. The lesson here is that, as in several other health care areas, often the good comes with the bad.

The Ugly

Taxability of Incentive Payments Made by CMS to Health Care Providers for the Implementation of EHR Systems

As noted earlier in this article, CMS has already paid significant amounts to hospitals, physicians, and other eligible health care professionals that have adopted and implemented the use of EHR systems. Moreover, these payments will continue through the end of 2016. Although a number of hospitals that receive these payments are tax-exempt under federal law, what are the federal tax consequences to eligible providers that are *not* tax-exempt?

In February 2013, shortly after 2012 tax forms were released by the Internal Revenue Service (IRS), health care providers received the "ugly" news — that these payments were taxable as and when received even though they were likely used to partially offset the non-deductible cost of purchasing EHR systems. (Generally, the cost of EHR systems would be capitalized since the systems have longer than a one-year useful life.)

Through this guidance (issued in the form of a Chief Counsel Advice, or CCA), the IRS concluded that recipients of incentive payments from CMS under ARRA to utilize EHR systems must include the amounts received in their gross income and that CMS must annually report to the IRS through a Form 1099 the identity of the taxpayers who received these payments and the payment amount. In short, the IRS reminded physicians and hospitals of their obligations to include EHR incentive payments in income.

In the CCA, the IRS indicated that because the ARRA-authorized incentive payments do not technically constitute reimbursement for the expenses incurred in establishing EHR systems, the payments must be included in income by the recipients as they are received. This conclusion applies even if the recipient is subsequently audited as to meaningful use and must refund to CMS all or part of the incentive payments.

In addition to addressing the taxability of the incentive payments, the IRS provided guidance about how the reporting obli-

gations are to be complied with in the case of employed physicians. In those cases, the actual recipient (typically, the employing hospital) must report the payment. Thus, where the recipient of the payment (typically, the employed physician) has assigned the right to incentive payments to a third party (such as an employer hospital), CMS must report to the IRS the payments to the payee (the physician or physicians group), which must then report (via another form 1099) its transfer of the payment to the ultimate payee of the incentive payments (the employer hospital). This will result in an additional administrative burden on the recipients of the payments (both the physician or physician group and the employer hospital) — having to issue a second Form 1099.

This requirement of dual reporting of incentive payments made to employed physicians is an example of the "ugly" tax aspects of the EHR systems incentive program. Although a health care provider that elects to purchase EHR systems and participate in the ARRA incentive payments program must include the payments from CMS in income for federal tax purposes, it likely cannot offset from income the payments received through an expense deduction since the cost of the EHR system cannot be expensed but must be capitalized for federal tax purposes.

In conclusion, the decision as to whether to take advantage of ARRA-authorized incentive payments for the adoption and implementation of EHR systems contains "good" and "bad" elements. Federal and state laws and regulations may limit or even prevent the donations of EHR systems to physicians and other providers of health care services. Where the physician or other health care professionals cannot secure discounts through partially donated EHR systems but actually must pay for the systems and thus be eligible to receive incentive payments from CMS under ARRA, the "ugly" result is that the payments from CMS are income as received for federal income tax purposes, and this income may not be offset with expense deductions for the cost of EHR systems, which must be capitalized. As a result, the user of the EHR systems may end up "going out of pocket" for the federal tax cost of the incentive payments. This is the "ugly truth" of donated EHR systems.

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