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Perspectives on health care legal issues

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Why it pays to limit executive compensation

During the past several years, executive compensation in the world of nonprofit and tax-exempt organizations has been at the forefront of issues tackled by the IRS, Congress, state officials and the media.

Ongoing scrutiny persists

Examples of the intense scrutiny being given to the issue since 2004 include:

Executive compensation audit initiative. In 2004 and 2005 the IRS sent letters to about 2,000 charitable organizations asking for a complete description of how they establish and report executive compensation.

Letter of inquiry for hospital systems. In May 2005, Senate Finance Committee Chairman Charles Grassley sent a letter to 10 hospital systems asking them to proffer information on their charity care and community benefits, joint ventures with for-profit entities, research and teaching activities, compensation arrangements with physicians and other professionals, and travel expenses for their top five salaried employees.

GAO Executive Compensation Survey. In 2005 and 2006, the Government Accountability Office sent a survey to 100 large, nonprofit health systems. Senator Grassley expressed disappointment at the number of health systems that didn't participate — only 65 responded — and called for scrutiny of supplemental executive retirement plans (SERPs). He also expressed concern that the respondents' governing boards weren't sufficiently involved in the compensation-setting process of their executives.

Hospital community benefit questionnaire. In 2006, the IRS distributed approximately 450 Forms 13790, "Compliance Check Questionnaire for Tax-Exempt Hospitals," to hospitals nationwide. Even though the survey primarily focused on

Appeals Court reverses *Caracci*

The first-ever reported intermediate sanctions case, *Caracci v. Commissioner*, arose because of the conversion of three home health agencies from exempt organizations to for-profit S corporations in 1995. The taxpayers, who ran the home health agencies and became the owners of the for-profit S corporations, claimed that the home health agencies' liabilities exceeded its assets, resulting in no taxable gain to the taxpayers on conversion. The IRS disagreed, however, and assessed millions of dollars in taxes and penalties under the Intermediate Sanctions Law. The Tax Court subsequently upheld $69 million in taxes and penalties.

In July 2006, the Fifth Circuit Court of Appeals reversed the decision in *Caracci* without remand, based on determinations that the IRS had failed to meet its burden of proof and that the Tax Court had made clearly erroneous factual findings and used an improper valuation method.

The *Caracci* cases underscore the importance of establishing the rebuttable presumption of reasonableness, which generally can be done by properly documenting decisions and obtaining sound valuation reports. Once the presumption is established, the burden of proof regarding fair market value shifts to the IRS, organization managers receive a safe harbor from possible excise taxes, and the IRS has less opportunity to attack an organization's tax-exempt status.

how hospitals meet the community benefit standard, it also included nine questions about how they set compensation for disqualified persons (as defined by the Intermediate Sanctions Law — see below).

Organizations suffer tax consequences

The IRS has several weapons at its disposal to combat situations of excessive compensation. The agency can turn to the private inurement doctrine that prohibits below-fair-market-value transfers to insiders.

The private benefit doctrine, which isn't limited to insiders, prohibits a nonprofit from operating for noncharitable purposes. They may provide benefits to persons in their private capacity under this doctrine, but such benefits must be incidental in relation to the furthering of exempt purposes. For example, a nonprofit promoting classical music programming on a commercial radio station constituted private benefit because the activities substantially benefited the radio station. If the IRS finds your organization guilty of either situation, its tax-exempt status could be revoked.

Another tool in the IRS' arsenal is the Intermediate Sanctions Law. Added to the tax code in 1996, this law gives the IRS an enforcement tool in situations where revoking a nonprofit's tax exemption is too harsh. It imposes penalty excise taxes on transactions between certain tax-exempt organizations and "disqualified persons" (similar to insiders) that don't constitute fair market value. (See "Appeals Court reverses *Caracci*" on page 2.)

Approach executive compensation carefully

To ensure the compensation your organization pays its executives is reasonable, incorporate the following into your policies and procedures:

> Your board of directors or an authorized committee of the board, made up of individuals who don't have a conflict of interest, should approve the transaction's terms in advance.

> Your board or other authorized body must obtain and rely on appropriate comparability data to determine the proper level of compensation for your executives.

Finally, the authorized body must adequately document its decision and provide the reasons for how it determined the executive compensation, including the terms of the transaction and the date it was approved; board members and others who were present during deliberation and voted on the arrangement; comparability data used and how it was obtained; and if any members abstained from voting because of a conflict of interest.

Not a laughing matter

It's obvious that the IRS and other parties are scrutinizing excessive executive compensation. To make sure your compensation arrangements make the grade, establish and follow policies that comply with the Intermediate Sanctions Law and the private inurement and private benefit doctrines. <

OIG 2007 work plan

What's in store for Medicare hospitals and physicians?

Each year the Office of Inspector General (OIG) issues a work plan to encourage efficiency and effectiveness in federal health care programs, including Medicare and Medicaid. The plan provides valuable insight into areas the OIG considers vulnerable to fraud and abuse. Think of it as a "cheat sheet" with regard to the OIG's targeted areas of investigation.

Hospitals

Here are some areas of the work plan that have particular importance to Medicare hospitals:

Hospital capital payments. Capital payments include expenditures for assets such as equipment and facilities. The OIG will examine Medicare inpatient capital payments, including the accuracy and appropriateness of the current methodology to update the capital rates. It will also determine whether hospitals have used capital payments for their intended purpose.

Outpatient department payments. The OIG will determine whether payments made under the outpatient prospective payment system were made according to Medicare laws and procedures, with particular focus on the appropriateness of payments for multiple procedures, repeat procedures and global surgeries. The OIG also will examine claims submissions from hospitals and other providers for services that should have been "bundled" into outpatient services for payment to determine whether the unbundling of these services led to inappropriate Medicare expenditures.

Rebates paid to hospitals. The OIG allows hospitals to receive a discount or rebate on purchased items so long as certain requirements are met, such as accurately reporting the discount or rebate. The agency is particularly interested in finding whether hospitals are appropriately identifying purchase credit rebates as a separate line item on their Medicare cost reports. The OIG plans to not only visit large vendors and examine the amount of rebates they've paid to hospitals in a given year, but also examine a sample of hospital cost reports to determine whether such rebates were properly reported.

Inappropriate payments for diagnostic X rays in emergency rooms. Beginning in fiscal year 2008, the OIG will examine the extent of inappropriate payments that have been made for diagnostic X rays performed in hospital emergency rooms. In 2004, more than 2.5 million diagnostic X rays were performed in Medicare-certified hospital emergency rooms. Because interpretations by ER physicians shouldn't be billed separately, the OIG will examine whether inappropriate payments were made for such interpretations.

Long-term-care hospitals. Since 2002, Medicare has paid long-term-care hospitals (LTCHs) under a prospective payment system that applies a larger base payment and different relative weights to the LTCH. Since that time, according to the OIG, the number of LTCHs has grown more rapidly than any other postacute setting. The OIG is especially concerned with LTCHs

that admit patients from a single acute-care hospital and, therefore, effectively function as a unit of that hospital. The OIG will further examine compliance with the length-of-stay criteria to ensure that the LTCH isn't reimbursed as an acute-care hospital, which is typically at a lower reimbursement rate.

Critical access hospitals. These hospitals are reimbursed reasonable costs for their inpatient and outpatient services. Because this may result in higher reimbursement amounts to the provider, the OIG plans to review cost reports from these hospitals for inpatient and outpatient services both before and after conversion to critical-access hospital status.

Specialty hospitals. The OIG will continue to assess the CMS's oversight of physician-owned specialty hospitals to ensure patient safety and quality of care at these hospitals.

Physicians and other health professionals

The OIG's work plan will also have an impact on Medicare physicians and other health professionals for fiscal year 2007:

Billing service companies. The OIG will identify and review the relationships between billing companies and physicians and other providers to determine the type of impact such arrangements have on the provider's billings. For example, the OIG may be interested in determining whether there is some sort of link between a relationship with the billing service and a possible increased or inappropriate billing on behalf of the provider.

"Incident to" services. The OIG will evaluate the appropriateness of Medicare services performed "incident to" the professional services of a physician and determine whether the services meet the applicable standards for medical necessity, documentation and quality of care.

Medicare reimbursement of polysomnography. In response to the rapid increase in reimbursement for polysomnography and other sleep-medicine-related services — nearly 175% in 4 years — the OIG will initiate a study to determine the factors contributing to this increase and the appropriateness of such services billed to Medicare.

Advanced imaging services in physician offices. The OIG will continue to examine the appropriateness of imaging services, including MRI, PET and CT scans, provided in physician offices. In 2005, Medicare allowed charges of more than $7 billion for such services. The agency will examine the nature of this growth, including the billing patterns in certain geographic areas and practice settings.

Include work plan in your planning

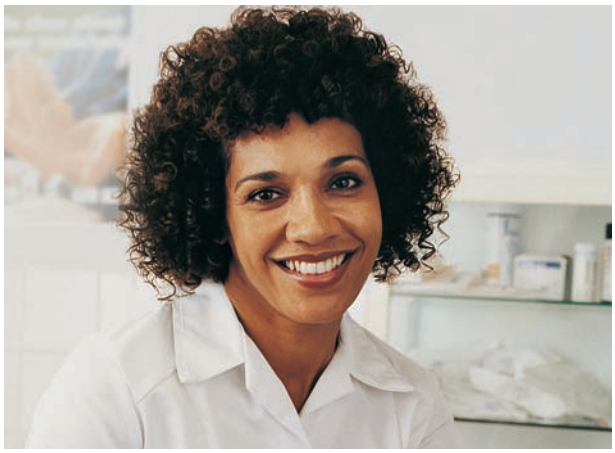
The work plan is helpful in identifying corporate compliance risk areas and providing focus for providers' ongoing efforts relating to compliance plans, policies and activities. Take time to review the plan and ensure that your internal policies and procedures address the risk areas identified by the OIG. <

How the pendulum swings

Medical residents and FICA tax

All employers and employees must pay FICA tax on wages earned, unless a specific exception applies. And such an exception for medical residents was introduced in 1998 by *Minnesota v. Apfel*.

In *Apfel*, the Social Security Administration (SSA) had sought to treat stipends paid to medical residents as wages earned and, therefore, subject to FICA taxes. These stipends hadn't been subject to FICA taxes because Minnesota had an agreement with the SSA specifically excluding any service performed by a student. The Eighth



Circuit upheld the district court's decision that medical residents were, indeed, excluded students under the agreement.

Case closed, right?

The IRS takes its stand

Although the *Apfel* case didn't directly reach the statutory exception for students found in the Internal Revenue Code, it spurred many other hospitals to stake their claims on the student exception in Section 3121(b)(10) and file for refunds or stop paying FICA taxes altogether for their medical residents.

The IRS didn't take this lying down. It sought to recover unpaid or refunded FICA taxes from various entities and eventually took the issue to court.

In the August 2003 *U.S. v. Mayo Foundation* case, the U.S. District Court for the Southern District of Florida found that medical residents did qualify for the student FICA exception in Sec. 3121(b)(10). The court applied the student FICA exception broadly to reach its conclusion. For example, for the exception to apply, the "student" must be performing services in the employ of "(A) a school, college, or university, or (B) an organization described in section 509(a)(3)… ."

In other words, the court found that the Mayo Foundation was a "school," and the medical residents were there to further their postgraduate education.

The IRS is still taking a stand

Despite these two court cases, the IRS has consistently challenged refund claims made for FICA taxes relating to medical residents and attempted to recoup refunds that it believes it paid erroneously.

The IRS claims the history of amendments to the Social Security Act makes it clear that Congress didn't intend for interns and medical residents to qualify under the student exception when it eliminated a separate exemption for interns. This argument gained a foothold with *U.S. v. Mount Sinai Medical Center of Florida*. The U.S. District Court for the District of Minnesota in *Mount Sinai* opined that *Mayo Foundation* reached the wrong conclusion, and, in so doing, declined to follow based on the legislative history of the FICA tax exception.

But, there's more …

It appears the IRS has won this battle. In December 2004, it issued final regulations, amending the qualifications for the student FICA exception. Treasury Regulation Section 31.3121(b)(10)-2 effectively denies the exception to medical residents situated similarly to those in *Mayo Foundation*, effective for services performed on or after April 1, 2005.

Under the new regulation, an organization is a "school, college or university" if its primary function is to present formal instruction, and it has a regular faculty and curriculum and a body of students in attendance where its educational activities are regularly carried on.

But the kicker is that, for an institution to be a school, college or university, its primary purpose must be *education*. Thus, many hospitals that sought to be classified as a "school" under *Mayo Foundation* for purposes of the student FICA exception now are outside the application of the exception.

The final chapter?

With the issuance of these final regulations, the widespread application of the student FICA exception to medical residents appears to have faded for services performed after April 1, 2005.

But what about medical resident services provided before April 1, 2005? Unless the *Mount Sinai* case is overturned on appeal, the IRS now has support for its position that medical residents aren't eligible for the student FICA exception. If the IRS prevails on appeal, it's likely it will champion the ruling in other Circuits. However, recent cases (such as *U.S. v. University Hospital, Inc.*) indicate that some courts will still review the application of the student FICA exception to medical residents on a facts and circumstances basis.

Moreover, the IRS is preparing a settlement initiative to handle the thousands of FICA refund claims filed by residents and teaching hospitals regarding prior tax years.

The regulations and your hospital

In light of the final IRS regulations on the matter, you should make plans to begin withholding FICA tax from all your medical residents' paychecks. As for any refund claims you may have filed with the IRS since April 1, 2005, there's still some uncertainty as to how those will be handled. But if you wish to file refund claims for FICA taxes paid in calendar year 2003, be sure you file them by April 16, 2007, to fall within the statute of limitations for those claims. <

New public disclosure requirements

Last August the Pension Protection Act of 2006 (PPA) became law. As would be expected from its name, PPA focuses primarily on pension reform. However, it also made several other modifications to federal tax law in the areas of charitable giving, estate planning and tax-exempt organizations, such as not-for-profit clinics and hospitals. Of particular interest to tax-exempt organizations are the new public disclosure requirements for return information.

More transparency

Prior to PPA, 501(c)(3) organizations were required to make available to the public their exemption applications (Form 1023 or 1024) and their three most recent Form 990s. One of the act's provisions expands these public disclosure requirements to include Form 990-T, "Exempt Organization Business Income Tax Return," which reports unrelated business income tax (UBIT).

Clearly, the goal of the new law is to provide more information to the public about Section 501(c)(3) organizations, such as the types and extent of unrelated business activities, in order to obtain a more complete understanding of their operations.

An interesting aspect of the new law is that the IRS isn't obligated to share Form 990-T with the public, which is the case with Forms 1023, 1024 and 990. So, 501(c)(3) organizations may experience more frequent requests from the public for this information. If you receive a request for a copy of your Form 990-T, you must provide it. If the request is made in person, you must provide a copy immediately, and if made in writing, you have 30 days to provide it to the person or entity requesting it.

To ease the administrative burden of these requests, develop a procedure for making the form available, whether you post it on your Web site along with other public reports, keep copies on hand, or create a comprehensive report of all forms that have been made public under current laws.

One thing you shouldn't disclose, however, is the name or address of any contributor to the organization.

More accountability

PPA also adds new reporting requirements to Form 990 to track all funds transferred between a controlling organization (defined as owning more than 50% of the controlled organization) and its controlled subsidiaries. Thus, a 501(c)(3) organization that files Form 990 must now report:

> Any interest, annuities, royalties or rents received from each controlled entity;

> Any loans made to each controlled entity; and

> Any transfer of funds between the controlling organization and each controlled entity.

These provisions apply to returns due after Aug. 17, 2006.

A message to our clients and friends:

Hall Render is pleased to provide you with this issue of ***Practical Health Law***. This newsletter will be sent to you bi-monthly compliments of our health law attorneys; each issue will also be housed in the **Articles and Newsletters** section of **www.HallRender.com**.

We understand the value of good information when making sound business decisions. ***Practical Health Law*** is written by Hall Render's health law attorneys, each with extensive experience handling the legal issues of health care providers. We trust the information in each issue will be a valuable resource. Our attorneys stand ready to respond promptly to your questions and needs; please contact us if there are specific topics you'd like to see addressed.

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