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Letters to the Editor

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Former HealthSouth CEO indicted for 85 counts of fraud

by Jennifer Carsen, J.D., Contributing Editor

Richard M. Scrushy, former CEO and chairman of the board of HealthSouth, has been charged with 85 counts of fraud as part of a far-reaching scheme to fraudulently inflate HealthSouth's revenue by billions on publicly filed reports. Scrushy is the first CEO accused of violating the Sarbanes-Oxley Act, which requires CEOs and CFOs to accurately and truthfully certify financial reports.

HealthSouth is based in Birmingham, Alabama, and is the country's largest provider of outpatient surgery, diagnostic imaging, and rehabilitative health care services. It has approximately 1,800 locations in the United States, Puerto Rico, the United Kingdom, Australia, and Canada.

The indictment, issued by the U.S. District Court for the Northern District of Alabama, charges Scrushy with 85 counts of conspiracy, mail and wire fraud, securities fraud, false statements and certifications, and money laundering. The indictment claims that from 1996 through 2003, Scrushy and other HealthSouth officers and employees made false and fraudulent entries to HealthSouth's books, adding approximately $2.7 billion in fictitious income.

The indictment alleges Scrushy laundered his illegally obtained income through a series of purchases, including a $302,950.75 Rolls Royce and a $3,225,000.00 Cessna airplane. The indictment demands the forfeiture of these and a variety of other items totaling over $278 million, including four residences, jewelry, boats, and paintings by Picasso and Renoir.

According to Assistant Attorney General Christopher Wray, "Instead of telling the public the truth, Richard Scrushy and his accomplices lied—they cooked HealthSouth's books and Scrushy personally vouched for false financial statements with the SEC to cover up their scheme."

If convicted of all charges, Scrushy could face up to 650 years in prison and $36 million in fines.

In a statement on his website, www.richardmscrushy.com, Scrushy maintains his innocence, saying, "I find this situation deeply disturbing, and I hope that our government moves swiftly to complete its investigations and free the company of this burden. At the same time, I want you to know that many of the allegations being reported in the media are false, and I look forward to a day when the truth regarding HealthSouth surfaces." ■

CCH Chicago Bureau, October 29, 2003

Tenet urged to comply with Senate document requests; Investigation widening

by Jennifer Carsen, J.D., Contributing Editor

A series of recent letters by Senator Chuck Grassley (R-IA), chair of the Committee on Finance, highlights the progress and scope of an investigation focusing on California-based Tenet Healthcare.

On October 31, Grassley sent a letter to Edward A. Kangas, chairman of Tenet, requesting that Tenet fully comply with the committee's document requests. On September 5, the Committee had requested documents and information from Tenet about patient deaths and complications due to medically unnecessary surgeries and procedures at Redding Medical Center. Grassley's letter noted that Tenet, through its attorneys, has been producing documents and information responsive to the Committee's request.

However, Grassley said Tenet has not yet provided the Committee with the findings and results of an independent investigation conducted by Mercer Human Resource Consulting. Tenet and its attorneys claim the Mercer documents contain privileged information. However, Grassley said he was "perplexed" at Tenet's decision not to share the Mercer findings, because "there is no better way for Tenet to demonstrate its intent to restore its reputation and credibility".

Grassley noted that Tenet released Mercer findings regarding another of its hospitals, the Queen of Angels-Hollywood Presbyterian Medical Center. "Evidently," says Grassley, "Tenet believes it can pick and choose when it will release Mercer's independent findings about problems at Tenet hospitals. When it appears self serving, such as when Tenet seeks to place blame elsewhere, Tenet will release information."

Grassley said that a recent request by the U.S. Attorney's office in Los Angeles for Tenet documents relating to certain doctor and billing arrangements "adds to my concerns about Tenet's corporate governance practices with respect to federal healthcare programs." Grassley said if Tenet failed to fully comply with the Committee's requests, a subpoena could be issued.

A few days later, on November 3, Grassley wrote to David Hedwig, President of Blue Cross of California (Blue Cross). In that letter, Grassley requested that Blue Cross cooperate with the Committee's investigation of Tenet. Grassley discussed a *Los Angeles Times* article reporting that Blue Cross had data suggesting that doctors at Tenet's Redding and Modesto hospitals performed unnecessary heart surgeries. Specifically, the *Times* quoted Dr. Woodrow Myers, Blue Cross' chief medical officer, who stated that he had reviewed 52 bypass operations at those hospitals and concluded that 85 percent of those at Redding and 59 percent of those in Modesto had been unnecessary.

On November 7, Grassley asked the federal Health and Human Services Department Office of Inspector General to investigate whether Tenet's Modesto hospital might have performed unnecessary cardiac procedures and surgeries and billed the federal government for them. In his letter to Dara Corrigan, Acting Principal Deputy Inspector General, Grassley once again cited the *Los Angeles Times* story quoting Meyers. ■

CCH Chicago Bureau, November 7, 2003

Physician's exclusion from Medicare was proper

by Richard C. Sarhaddi, Esq., Contributing Editor

Brij Mittal, M.D. was convicted of one count of conspiracy to receive unlawful Medicare kickbacks in violation of 18 U.S.C. § 371 and three counts of unlawful receipt of kickbacks in violation of 42 U.S.C. § 1320a-7b(b)(1) in a jury trial by the United States District Court, Southern District of New York. In an ensuing, separate action brought by the Inspector General, the administrative law judge (ALJ) determined that Mittal would be mandatorily excluded from participation in the Medicare program for a period of five years for the violations for which the physician was found guilty of by the district court. In addition, the ALJ extended the minimum five-year exclusion to ten years due to three aggravating factors with no mitigating factors. The physician appealed the ALJ's decision to the Departmental Appeals Board-Appellate Division.

Physician's arguments. On appeal, the ALJ's decision was partially upheld and partially reversed. Mittal argued that the payments he received for referring his patients to medical

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suppliers and service providers were not kickbacks because they did not result in any loss to the Medicare program and because his referrals were medically necessary. The Departmental Appeals Board-Appellate Division responded that it is irrelevant whether the Medicare program actually sustained a monetary loss. It explained that the criminal laws in place demonstrate that Congress has determined that it is harmful to the Medicare program to refer beneficiaries to particular medical suppliers or service providers rather than basing the referrals solely on the beneficiary's best interests without a kickback incentive. In addition, the Appellate Division stated that the § 1128(a)(1) of the Social Security Act requires only that there be a nexus between the criminal acts and the delivery of an item or service under the Medicare program, and that *clearly* such a nexus existed in this case.

Appellate Division's determination. The ALJ determined that the physician's ten-year exclusion from the Medicare program was proper. The ALJ, however, improperly granted summary judgment to the Inspector General concerning mitigating circumstances pertaining to the physician's cooperation with federal officials, and therefore, the case was remanded to the ALJ to determine whether the physician can establish such mitigating factors. ■

Brij Mittal, M.D. v. Inspector General, ¶180,071

Four-hour strike delay cost nurses their jobs

by David Stephanides, J.D., Contributing Editor

A healthcare clinic lawfully discharged its striking nurses because their union failed to comply with the literal requirements of the National Labor Relations Act (NLRA), Section 8(g), ruled the National Labor Relations Board (NLRB) in 3-2 decision. There was a delay in the start of their economic strike of four hours after the time set forth in their union's required 10-day advance notice to the employer. Chairman Battista, Members Schaumber and Acosta reversed the administrative law judge and held that a union cannot unilaterally extend the commencement time of its strike. Members Liebman and Walsh dissented (*Alexandria Clinic, P.A.*, 2002-03 CCH NLRB Decisions, ¶16,521).

In this instance, per Section 8(g)'s requirement that labor organizations give healthcare institutions 10 days' advance written notice of the date and time of its intended strike, the union informed the clinic that it would strike on September 10, 1999, starting at 8 a.m. On September 7, members of the union's negotiating committee changed the commencement time of the strike from 8 a.m. to noon. It was decided, however, that neither the nurses nor the clinic was to be notified of this change. Claiming that the strike was illegal, the clinic wrote to the striking nurses that their walkout was "in violation of the notice provisions of Section 8(g)" and that their employment was, therefore, terminated.

The majority noted that the last sentence of Section 8(g) says that the 10-day "notice, once given, may be extended by the written agreement of both parties." Given this clear language, they stated that a union cannot unilaterally extend the commencement time of its strike and to the extent that the Board's decision in *Greater New Orleans* (1978-79 CCH NLRB Decisions ¶15,514) holds to the contrary, they overruled it. Member Acosta agreed with Chairman Battista and Member Schaumber that the Board inappropriately relied on legislative history to turn clear statutory language on its head. Therefore, he joined them in overruling Greater New Orleans.

Dissenting, Members Liebman and Walsh concluded that pertinent provisions of Sections 8(g) and 8(d) are ambiguous with respect to the situation at hand. "Applying a rule of reason derived from these legitimate guides to Congressional intent—and not the majority's mechanical approach—demonstrates that the discharged nurses did not lose the protection of the Act and that their employer did indeed [unlawfully discharge] them." They argued that the "result reached today would surely appall the Congress that enacted Section 8(g), even if it does not trouble the majority." ■

CCH Chicago Bureau, November 3, 2003

Corporate governance: Duty of care and duty of loyalty

by John E. Steiner, Jr., Esq.

This article complements an earlier article ("The New Face of Corporate Governance" by Paul DeMuro, J.D., CCH Healthcare Compliance Letter, Volume 6, Issue 14) on the general principles of the Sarbanes Oxley Act (SOX), 107 Pub.L. No. 204, 116 Stat.745, and corporate governance. That article addressed many of the SOX requirements that apply to all publicly disclosing companies, both domestic and foreign, their officers, directors and shareholders, as well as accounting and legal professionals.

Among the many provisions in SOX, one that has become of particular interest to directors of corporations is the direct responsibility placed on the Audit Committee for the audit relationship with the corporation's independent auditors. In addition, one of the strongest messages in SOX is for directors to be more proactive in staying informed of the corporation's business activities and to critically consider the frequency and content of reports prepared for them by senior management and third parties.

In a broader context, recent developments in the legal and business worlds highlight the responsibilities of directors to fulfill their fiduciary duties to the corporation. This article addresses the "duty of care" and "duty of loyalty" of directors of nonprofit corporations. The term "director" is used in this article to mean either a director or a trustee of a nonprofit corporation. In the nonprofit corporation world, most state statutes refer to a "board of directors." However, other terms may be used to describe a governing body whose members are responsible for fulfilling fiduciary duties. For example, the term "trustee" or "board of trustees" may be used by nonprofit corporations in their organizational documents. But in most state nonprofit corporation laws, and for purposes of the Model Nonprofit Corporation Act published by the Business Law Section of the American Bar Association (ABA) in 1987, the term "trustee" is *not* equated with the trust law standard of care imposed on a trustee of a trust. In any case, it is advisable to know how your state nonprofit corporation act has been interpreted with respect to the legal duties imposed on directors of nonprofit corporations.

The "duty of care" and "duty of loyalty" are established under state law, common law, and model corporation laws. For example, the 1984 Model Business Corporation Act and the ABA 1987 Revised Model Nonprofit Corporation Act set forth fairly similar standards that apply to directors of both for-profit and nonprofit corporations.[1] Delaware, a popular state for business incorporations, has perhaps the longest and most storied line of interpretive case law on the topics addressed in this article, especially as applied to for-profit corporations. Therefore, it is instructive to carefully analyze decisions by the Delaware courts pertaining to the fiduciary duties of directors.

Fundamental Principles

Underlying the law applicable to nonprofit corporations is the doctrine of "charitable trust." That is, rather than primarily serving the interests of shareholders, as is the case with proprietary corporations, a nonprofit corporation is created to fulfill a charitable purpose or mission. Education and health care readily come to mind as preeminent examples of charitable trusts. Accordingly, those in governance positions with a nonprofit corporation owe a duty to further the corporation's business purpose and protect its charitable trust assets. There is an important and somewhat complex area of law that addresses directors' duties when a corporation is insolvent; however, a detailed discussion of that topic is beyond the scope of this article.[2]

Two fundamental duties of directors of corporations have emerged over decades of litigation: the duty of care and the duty of loyalty. Both duties are treated extensively in law treatises, case law, the ABA 1987 Revised Model Nonprofit Corporation Act and the 1984 Model Business Corporation Act.[3] Under the Model Nonprofit Corporation Act, a director of the corporation or a committee thereof is required to discharge his or her duties:

- in good faith;
- with the care an ordinarily prudent person in a like position would exercise under similar circumstances; and
- in a manner that the director reasonably believes to be in the best interests of the corporation.[4]

Duty of Loyalty

The duty of loyalty generally requires a director to exercise his powers in good faith and in the best interests of the corporation, as opposed to acting in his own interest or the interests of another

person or entity. Stated alternatively, a director must be vigilant not to use his position for personal advantage. Thus, the duty of loyalty bears most directly on issues of conflict of interest, business opportunity for the corporation, and confidentiality of business information, plans, and the like associated with the corporation.

Duty of Care

A fundamental assumption that supports the duty of care is that the director will act with common sense and make decisions based on informed judgments. However, a director is not expected to be a guarantor of the success of an outcome of a particular decision or course of action undertaken by the corporation. In many situations, directors must rely on senior and executive management reports, representations, and the like when exercising their judgments. Thus, sound internal controls, financial accounting practices, and compliance programs are important methods for reassuring the directors that the corporation is demonstrating good faith efforts to be legally compliant.[5] Clearly, in fulfilling their fiduciary duties, directors must place reasonable reliance on senior management. Thus, the better informed senior management is, the greater the probability that reliable information will also reach the Board of Directors. Consistent with their duty of care, directors should be adequately briefed and, therefore, likely to be in a position to ask useful questions and make decisions on various corporate matters, such as "off balance sheet transactions," business arrangements with third parties or other Board members, etc.

Regardless of whether a company is a publicly disclosing corporation or not, it is important to recognize that both individuals and corporations can be punished criminally for certain conduct. While it is true that corporations do not go to jail, they can be subjected to criminal fines. SOX added Section 1519 to Title 18 of the United States Code, where federal criminal statutes are codified. That section carries criminal penalties for false entries, document alterations, concealment or destruction "with the intent to impede, obstruct, or influence the investigation or proper administration of any matter within the jurisdiction of any department or agency of the United States." Directors should understand this aspect of SOX and appreciate the scope of the legal definitions of such acts.

To fulfill this duty to the corporation, the individual director must be informed and exercise independent judgment in a number of ways. Here are a few examples:

1. **Regularly attend and vote at meetings, including committee meetings.** Most state laws provide flexibility for directors to satisfy meeting attendance requirements by use of electronic communication. Nonetheless, personal attendance is a preferred business practice and probably a more supportable way to fulfill this aspect of the duty of care. With respect to committee meetings, active participation and deliberation of agenda items by directors should be the norm, not the exception.
2. **Exercise independent judgment.** In its simplest and most important sense, each director is to make decisions based on what is in the best interest of the corporation. Each director must recognize that the law views the Board of Directors as an entity and that each director has the same rights and responsibilities as fellow directors. In exercising their authority as board members, the directors are expected to raise questions, provide specialized knowledge or expertise, share experiences, etc., all with the objective of doing what is best for the corporation.
3. **Stay informed.** As discussed above and since SOX, more extensively in the legal and business communities, directors are expected to be more proactive, interested, and versed in the corporation's affairs. To do so, individual directors should be focused on both the quantity and quality of information about the corporation that is provided to them by the corporation's officers or agents, such as the independent financial auditors.
4. **Rely on information.** The duty of care imposed on a director does not require the director to be an expert in all aspects of the corporation's business or its operations. Thus, a director may reasonably rely on corporate sources of information that the director "reasonably" regards as trustworthy. Clearly, on this point SOX plays a substantial role in that Section 302 requires "certification" requirements from the CEO and CFO and Section 906 carries criminal sanctions for improper or deficient "certifications."
5. **Delegate.** While the board may be described in state corporation law as responsible for "managing" the business and affairs of the corporation, it is commonly accepted that the operation of the corporation is the responsibility of officers and agents. Oversight, with proper delegation of operational authority to the officers and agents, is the domain of the directors. Oversight includes periodic monitoring and critical analysis and discussion of periodic reports to the Board, especially the independent auditor's letter to management.

In general, the combined effects of SOX and the well-established examples of a director's duty of care described above should prompt the Board of Directors to routinely ask open-ended questions at meetings, especially Board committee meetings. By doing so and "testing" the adequacy and accuracy of information presented, directors can demonstrate their commitment to fulfilling their fiduciary duties to the corporation.

As Chief Compliance Officer and Privacy Official for the Cleveland Clinic Health System, Mr. Steiner is responsible for the design, implementation and administration of the compliance programs for a multi-state, integrated delivery system that includes an academic medical center. The compliance programs include requirements of government and private payors, clinical research, and HIPAA.

His health care expertise includes: health care compliance matters, Medicare, managed care payment and contracting, fraud and abuse, Stark law, False Claims Act matters, tax-exemption, antitrust, JCAHO accreditation, and patient anti-dumping laws.

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Structuring a nonprofit to for-profit conversion

by Catherine Hubbard, MA, Contributing Editor

When Health Midwest sold its hospital assets to HCA Inc., in reportedly the largest nonprofit to for-profit sale in history, the Kansas City-based integrated delivery system had to face scrutiny from attorneys general in both Missouri and Kansas. However, it succeeded in court because of sound planning. Douglas Anning, of Seigfried, Bingham, Levy, Selzer & Gee, Kansas City, Missouri, who represented the company, offered several insights into the way attorneys general tend to operate. He spoke at a fall American Health Lawyers Association conference in Washington, D.C.

Nonprofits that consider selling all or part of their assets should hold multiple rounds of competitive bids, Anning said. He noted that Health Midwest held four rounds of bids, during which the offer rose from $600 million to just over $1 billion. "It's good if you can structure a creative bidding process, where you have multiple parties trying to bid for the same assets." While the process drives the price up, it also helps to prove that the transaction was arms-length, he said.

Anning recommended nonprofits prepare the transaction thoroughly and do as much of the AG's job up front as possible. "It's important to do the job for them when you're structuring these transactions. Anticipate what the attorney general wants and include that in the transaction. If you seal the deal with your partner and then the attorney general comes in after the fact, you run the risk that your deal is going to get scuttled."

For instance, Anning recommended nonprofits scrutinize companies that are interested in buying. "Look at whether the buyer is going to be a good steward of assets, provide a service to the community and treat patients in need," he suggested. Health Midwest sent board members to visit facilities that prospective buyers, HCA and Tenet Healthcare Corp., had previously purchased from nonprofits. The research paid off when Health Midwest presented itself in court. "The judge pointed to that as evidence that we had satisfied the duty of care," Anning said. He noted that Health Midwest selected HCA to purchase its hospital assets, but it retained its home health, mental health and hospice divisions.

Nonprofits also should negotiate operating covenants before making a deal, Anning said. "It's easier to negotiate operating covenants up front." HCA knew it would have a $1.125 billion purchase price and several covenants to satisfy, amounting to $450 million in capital improvements and $500 million in charity care commitments. "If they had committed a purchase price and then after the fact the attorneys general had asked them to make other covenants, it probably would have broken the deal." The sale closed on April 1, 2003.

Anning recommended that organizations document the steps leading to the decision to sell. AGs will be interested in whether the board has considered all the alternatives for several months, including the option of getting rid of current management, joint ventures, mergers, sales, and affiliations with local hospitals or other entities—both for- and not-for-profit. "Document that in the minutes," he urged.

Once the nonprofit has decided to sell, it needs to articulate the rationale. It should mention operating loses, lack of access to capital, nursing and physician shortages and any problems it may have with integrating the system as much as needed. In the Kansas

Be prepared for a challenge from the Attorney General

There are several factors attorneys general are likely to examine whenever a nonprofit health care entity sells assets to a for-profit, according to Douglas Anning, of Seigfried, Bingham, Levy, Selzer & Gee, Kansas City, Missouri. Knowing how AGs think can make the difference between a successful transaction and a sale that gets blocked.

For instance, AGs will want to:

- Look out for key constituencies, including patients, employees and physicians. "They want to make sure that the community has continued access to affordable health care," said Anning.
- Examine whether the conversion will lead to hospitals or emergency rooms closing and to the discontinuance of key loss leader services. "The attorney general is going to want to know about all these key issues," he said.
- Make sure that employees are going to keep their jobs and their benefits and to make sure that physicians will keep their medical staff privileges.
- Look at the fair market value of the transaction. "AGs want to know what the structure of the transaction is going to be and how the consideration will be paid," Anning said. The IRS will be interested in this issue also, he said.
- Safeguard charitable assets.
- Examine the use of sale proceeds.
- Make sure the board exercised due diligence during the sale. "They want to make sure that the board is not just rushing into a decision," said Anning. Boards should make sure they have considered all the alternatives that they have made rational decisions, especially in light of the Sarbanes-Oxley Act of 2002 (P.L. 107-204), he said. "It's important that the boards are doing the right thing."
- Take credit publicly for the operating covenants, even if they are negotiated by the nonprofit. "You've always got to remember that an attorney general is a politician by trade," he observed. "They need to take credit for all the good things that happen."

Nonprofits (cont.)

case, the judge relied on the minutes to decide that Health Midwest considered the alternatives and had a clear rationale for the sale. "Always put in anything that you want read, and don't include anything you don't want read in the minutes," he said.

Both the Missouri and the Kansas AGs publicly said they were focused on the "Three Ps"—process, price and proceeds. However, he said, "It quickly became clear that the public and the AGs were only concerned about proceeds." Once the AGs found out that $1 billion was going into a charitable organization, he said, they decided it was their money and they had a right to say how it was spent." It was like sharks swimming to blood," he said.

Both AGs threatened to dissolve Health Midwest, charging that it was abandoning its charitable purpose. Since it was clear the AGs were going to sue, Health Midwest decided to "beat them to the punch" and sue first, Anning said. "This helped Health Midwest choose a venue in both Kansas and Missouri," said Anning. He noted the case moved quickly to settlement in Missouri. In the Kansas case, Health Midwest won on almost every issue, he said. "It was painful at times, but in the end we closed the deal and that's a successful transaction," he concluded. ■

CCH Washington Bureau, November 13, 2003

On The Front Lines (cont.)

[1] ABA Revised Model Nonprofit Corporation Act, Section 8.30 (1987)).

[2] Readers can obtain a better understanding of the duties of directors for an insolvent corporation from an article in the *Journal of Health Law*, Spring 2002, Volume 35, No.2, published by the American Health Lawyers Association and the Saint Louis University School of Law. That article is entitled, "The Fiduciary Duties of Healthcare Directors in the 'Zone of Insolvency,'" by Michael Peregrine, James Schwartz, James Burgdorfer, and David Gordon. The general principle is that the directors' fiduciary duty of care shifts somewhat when a corporation is insolvent, as defined in accounting terms and not bankruptcy terms. That shift requires the directors to assess how best to exercise their fiduciary duties for the interests of the corporation, which includes the creditors of the corporation and other groups, as opposed to exclusively serving the charitable mission or purpose of the corporation.

[3] For a thorough review of the Revised Model Nonprofit Corporation Act, see Lizabeth A. Moody, *The Who, What, and How of the Revised Model Corporation Act*, 16 N.Ky.L. Rev. 251 (1989).

[4] ABA Revised Model Nonprofit Corporation Act, Section 8.30(a) (1987).

[5] Such assurance is important, even before SOX, in light of Delaware case law that addressed potential, individual liability of directors. In the *In Re Caremark International Inc. Derivative Litigation* case, 698 A.2d 959 (Del.Ch.1996), the Delaware Chancery court noted that a failure by the Board of Directors to assure an adequate information reporting system that provides senior management and the Board with timely and accurate information related to legal compliance might, in some situations, be treated as a violation of a director's duty of care.

Quality of care: An issue for ESRD facilities

A large number of the approximately 4000 end-stage renal disease (ESRD) dialysis facilities do not achieve the minimum patient outcomes specified in clinical practice guidelines for a substantial number of their patients, according to a General Accounting Office (GAO) study. Furthermore, serious problems identified in CMS inspection reports would warrant termination from the Medicare program for approximately 15 percent of ESRD facilities.

The GAO identified 512 facilities that had 20 percent or more of their patients receiving inadequate dialysis treatment and almost 1,700 facilities that had 20 percent or more of their patients receiving inadequate treatment for anemia. Common problems include: improper clinical management, medication errors, improper use of reusable dialysis equipment, contamination of water used for dialysis, and insufficient physician involvement with patients.

In addition, GAO found that inspections conducted by state survey agencies often failed to detect or correct the ESRD facilities' quality of care problems. Specifically, state survey agencies reported inconsistent results, allowed many facilities to go on for years without inspections, and permitted inexperienced surveyors to conduct the inspections. Also, many facilities have had problems maintaining compliance with Medicare's minimum quality standards even after deficiencies had been recognized and corrected. Between 1998 and 2002, 18 percent of those facilities that had serious problems recognized and corrected had the same deficiencies present in subsequent inspections.

GAO recommended that CMS: (1) reduce the time between state inspections for facilities with serious deficiencies; (2) publish facilities' survey results on-line; (3) encourage states to hire surveyors that specialize in inspecting ESRD facilities; (4) increase the availability of training courses for state surveyors; (5) require networks to share facility data with state agencies; and (6) ensure that regional offices monitor state performance and provide state agencies with assistance on issues. In response to the GAO's recommendations, CMS indicated that it would address one of the six recommendations—specifically, CMS stated that they would increase the number of training courses for ESRD facility surveyors.

Source: General Accounting Office, GAO-04-63, October 8, 2003

Proving a charitable health care organization is worth its tax-exemption

by Catherine Hubbard, MA, Contributing Editor

To maintain tax-exempt status, nonprofit hospitals need to do more than simply provide uncompensated health care services to the community. They need to prove that the benefit to community health they offer wouldn't exist without the charitable purpose, according to Gerald M. Griffith of Honigman Miller Schwartz and Cohn, Detroit, Michigan.

Speaking at an October 22-23 American Health Lawyers Association conference in Washington, D.C., Griffith outlined the steps nonprofits can take to protect both their mission and their tax status. To qualify for Code Sec. 501(C)(3) status, organizations must:

- Be organized and operated exclusively for charitable, religious or educational purposes.
- Promote health. "IRS looks for the affirmative ability to do good; not just failing to do harm. Not all health care is charitable," he said.
- Lack any substantial non-exempt purpose.
- Conduct exempt activities commensurate with financial resources.
- Inure no more than an incidental private benefit.

A forthcoming decision in the *St. David's* case (5th Circuit Court of Appeals, Oral Arguments August 2003) should shed some light on the type of charity care hospitals need to provide to remain exempt from taxes, he said. "The St. David's case may provide more guidance." Even without the decision, Griffith said it's clear the IRS will look at whether a health care facility is open to the indigent, the elderly and substance abusers, rather than whether the mission "benefits the bottom line of the HMO."

The case also should clarify how hospitals account for bad debt, said Griffith. In fact, he said, one of the leading factors the IRS will look for is how the operation defines charity care. Bad debt, which is a patient's unwillingness—not his or her demonstrated inability—to pay, will not support the exemption. "Bad debt is not charity care, but is a subset of 'uncompensated care,'" he said. Griffith noted that many for-profits contend that virtually all uncompensated care benefits the community, as does payment of taxes.

Joint ventures. Regarding joint ventures between an exempt organization and a for-profit, Griffith said, the IRS will examine whether the venture improves cost, quality and access to services. Control is also an element, he said, noting that in Rev. Rul. 98-15, the IRS showed that it will look at whether the board is free of conflicts.

When entering into managed care contracts, Griffith advised hospitals to have open staff policies and to monitor and enforce the joint ventures' commitment to subordinate profits to the hospital's mission. "You can have all the rights in your joint venture document, but if you don't enforce those rights it will be of little effect." There should also be a tax dissolution clause that gives the hospital the right to dissolve the joint venture if continuation would jeopardize its tax-exempt status, he recommended.

Charity care policies. Any organization that relies on charity care policies for its community benefit must provide a reasonable level of charity care, Griffith said. "It's not enough to have a policy on the shelf. You actually have to implement it and make it happen." Institutions also need to let the pubic know about their ability to deliver charity care, he said. "If you don't let them know, then it's not benefiting the community."

Entities should use the Form 990 and attachments to state their exempt purpose. "Make your case for community benefit in the Form 990," Griffith said, noting that the Forms eventually become public. Minutes are also a good vehicle for showing exempt purpose, he said. "Minutes can either be a smoking gun or they can tell a positive story." He noted that the IRS typically reviews minutes during audits.

Also useful is conducting surveys and reviewing industry reports, Griffith said. "The needs assessment itself can be a community benefit," he emphasized. Griffith also recommended that tax-exempt hospitals encourage enrollees to give back to community. "Show how the organization can serve a broad cross section of the community," he advised.

Physician recruitment. After Rev. Rul. 97-21, tax-exempt health care organizations need to prove the exemption is necessary to retain or recruit physicians. But providers need to show that revoking the exemption would cause physicians to leave the whole community—not just the specific hospital, said Griffith. "People get confused by this. If you can show physicians are leaving the community and not just leaving your hospital, the IRS will be more lenient."

So far, the IRS is only going after nonprofits that are not providing much community benefit, Griffith told CCH after his speech. "The IRS is still being reasonable," he said. However, the courts are tougher, he noted. "[Tax-exempt status] is harder to prove to the court. It's not as difficult to prove to the IRS." ■

CCH Washington Bureau, November 1, 2003