Hospital employers and their management teams should be concerned. The IRS has placed tax-exempt hospitals under its magnifying glass with its Hospital Compliance Project. The goal: To study nonprofit hospitals and the community benefits they provide, as well as to determine how hospitals establish and report executive compensation. The probe could result in additional regulation, revenue rulings, and/or legislation.

Spurred by Senate Finance Committee concerns that laws governing tax-exempt hospitals have not changed in more than 40 years and by media reports of seemingly excessive compensation and loans to executives of charitable organizations, the IRS is taking a close look at the compensation paid to health care executives. It is also scrutinizing hospitals to determine whether and to what extent they provide a “community benefit,” a requisite for hospitals seeking and retaining tax-exempt status as charitable organizations under Section 501(c)(3) of the Internal Revenue Code.

The Community Benefit Standard

The present “community benefit standard” with which tax-exempt hospitals have to comply evolved from the earlier “charity care standard,” which was established in 1956 by IRS Revenue Ruling 56-185 and required that, in exchange for exemption from paying taxes, hospitals had to admit and treat patients who were unable to pay, either without charge or at rates below costs. Because uncompensated care had to be provided to the extent of the hospital's financial ability, this became known as the “financial ability standard.” In 1969, this standard was modified to require that, in exchange for exemption from paying taxes, a hospital must operate for the benefit of the community rather than to serve private interests. This community benefit standard was established after passage of the Medicare/Medicaid laws in the mid-1960s that provided medical care for the elderly and the poor, and made the charity care standard obsolete. The community benefit standard is still applied today to tax-exempt hospitals.

A hospital that is otherwise qualified for tax-exempt status also must meet the community benefit standard by meeting the following requirements:

- Has a board of directors composed of prominent citizens drawn from the community;
- Has a medical staff consistent with the size and nature of its facilities that is open to all qualified physicians in the area;
- Operates a full-time emergency room open to all persons without regard to their ability to pay; and
- Provides hospital care for everyone in the community able to pay the cost either themselves, through private health insurance, or with the aid of public programs such as Medicare.

Hospital Compliance Project Questionnaire

To assess how tax-exempt hospitals believe they provide a community benefit in exchange for tax-favored status, the Hospital Compliance Project team sent a questionnaire to 544 hospitals in May 2006. Not every one of the 487 responding tax-exempt hospitals answered every one of the 81 questions, resulting in a variation in the number of responses from question to question. An interim report has been issued which addresses only the community benefit standard. The IRS is still examining the data it received about executive compensation.

The survey sought information on the community benefit standard as well as executive compensation practices. The community benefit questions included queries about:

- Hospital type and patient demographics;
- Governance;
- Medical staff privileges;
- Billing and collection practices; and

Continued on next page
• Types of programs that might constitute community benefit, including
  – uncompensated care
  – medical education and training
  – medical research
  – other community programs

Here are some of the more important results:
• Uncompensated care accounted for 56% of the total community benefit expenditures reported by survey respondents.
• The next largest categories of expenditures for community benefit were medical education and training, research and community programs.
• The average community benefit expenditures reported was 9% of total revenues and the median was 5%.
• Significant variations were found in how hospitals reported uncompensated care. Although 97% of hospitals reported having a written uncompensated care policy, there was no uniform definition of what constitutes “uncompensated care” among the respondents.
• The treatment of bad debt expense as uncompensated care was mixed, with 56% reporting they did not include bad debt expense as uncompensated care, and the remaining 44% including at least some bad debt expense as uncompensated care.
• Hospitals also varied in reporting uncompensated care on the basis of costs or charges, and the treatment of the difference between gross charges and amounts received for providing care (shortfalls) to Medicare, Medicaid, uninsured, and other patients.

The IRS intends to continue to analyze all of the data and, in particular, try to determine what criteria hospitals use in determining whether to include bad debt expense as part of their expenditures for uncompensated care.

Lack of Uniformity Criticized
Commenting on the IRS’s interim report summarizing responses to the questionnaire, ranking Senate Finance Committee member Chuck Grassley (R-Iowa) bemoaned the lack of uniformity in the definitions used and discrepancies among survey respondents. According to Grassley, “The responses from the nonprofit hospitals make clear that the hospitals are all over the map in defining charity care. We need common terms and measurements so taxpayers can have confidence that nonprofit hospitals are providing benefits commensurate with the billions of dollars in tax breaks they receive every year.” He added, “The report makes clear that we need to change business as usual at many of our nation’s nonprofit hospitals.

These are self-reported numbers and often include inflated costs or bad debt. It’s troubling that even the overly broad figures paint a bad picture of a significant number of nonprofit hospitals doing very little charity care.”

Lois G. Lerner, director of the IRS’s Exempt Organizations division, agreed: “The lack of consistency or uniformity in classifying and reporting uncompensated care and various types of community benefit often makes it difficult to assess whether a hospital is in compliance with current law. That’s one reason more analysis is needed.”

IRS’s Next Steps
Much of the data from the questionnaires is still being processed. Additionally, the data has not been independently verified and analysis is incomplete. The usefulness of some of the reported data also is affected by:
• lack of uniformity in certain reporting practices and definitions;
• failure by some hospitals to respond to all of the questions;
• deficiencies in the manner in which certain questions were asked; and
• ambiguous responses.

For these reasons, the data may not capture adequately the community benefit actually provided by the respondents or by the nonprofit hospital sector as a whole. To address these limitations, the IRS Project Team’s next steps include the following:
1. Analyze the reported data to determine whether differences in reporting, such as the treatment of bad debt and shortfalls as uncompensated care, may be isolated and adjusted to allow more meaningful comparisons across the respondents.
2. Obtain additional research and analyze the differences in community benefit expenditure amounts and types to take into account varying demographics, such as rural and urban communities and hospitals.
3. Test the reported community benefit amounts and types by conducting data analysis, compliance checks, or examinations of individual hospitals, and by other means, including with respect to outliers in the reported data.

In September 2008 the IRS plans to publicly issue a final report summarizing the results of the tax-exempt Hospital Compliance Project.
What Affected Hospitals Should Do

It’s too early to know the nature of the regulatory mandates that may result from the IRS Hospital Compliance Project. However, both the questions asked and the planned next steps show that the IRS is targeting the community benefit standard and compensation practices. Here’s how nonprofit hospitals can prepare for the expected IRS scrutiny:

• **With respect to community benefit:** Be prepared to substantiate the type and quantity of community benefit you have provided. For instance, if uncompensated or discounted care is claimed as the benefit, records should be diligently maintained of the dates, patients, and type of care provided, as well as the percentage of total hospital hours devoted to such care. The types of care your organization deems to constitute uncompensated (or discounted) care should be carefully outlined. Hospitals also should conduct a practical analysis of the “value” of their tax exempt status and compare it to the free care and community benefits provided. Hospitals can be subject to criticism where there is an unfair asymmetry between the tax revenues sacrificed by the community and the benefits provided in return. Hospitals similarly should review their uncompensated and free care and related programs from the perspective of the community need and whether it is being met by the programs in place. Review of uncompensated and free care and related programs in relation to objective factors such as patient revenues, and in comparison to other, similarly situated hospitals, is warranted as well.

• **With regard to compensation practices:** As noted above, the interim report did not include any findings about compensation practices. However, executive compensation has been under intense scrutiny by unions, on websites, and in multiple other forums. As a tax-exempt organization, you must pay no more than reasonable compensation for services performed by officers, trustees, and employees. Nonprofit compensation practices are regulated by I.R.C. Section 501(c)(3), which prohibits inurement and private benefit. (Inurement involves an insider—whether an individual or an entity—who takes the exempt organization’s profits so as to benefit himself or herself. Private benefit includes those who are not only inside but also “outside” the organization.) Therefore, you should be prepared to show that the amount you pay is comparable to the compensation paid to similarly situated executives, employees and directors industry-wide.

For questions regarding community benefit and compensation practices, contact your regular Jackson Lewis attorney, or contact Attorney Howard Bloom at (617) 367-0025.

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Union Organizing Update

**SEIU’s Numbers and Influence Expanding**

The Service Employees International Union (SEIU) has the health care sector squarely in its sights. The union has launched an aggressive organizing campaign targeting 10 million non-union health care workers. Its tactics are proving successful in raising its profile and status—and in increasing its influence.

This summer, the SEIU certainly didn’t take a vacation. In fact, they’ve been busier than ever, launching SEIU Healthcare, which combines more than one million health care members from 38 SEIU locals into a new union with national reach. Many believe the SEIU has launched this new union in order to create some separation from its well-publicized recent organizing efforts among janitors and to establish its “brand” as a health care union to assist in organizing healthcare workers. Nevertheless, the new union’s stated goals are to:

• Develop innovative approaches to uniting more workers, and then duplicate those approaches across the country to grow stronger.
• Use its national clout to influence politicians.
• Use its national power to shape the future of health care.

Its first national effort is to collect a million signatures on a petition urging Congress to provide health insurance to uninsured children. On its face, that’s a laudable goal, of course: with an estimated 8.3 million uninsured children in America, it is hard to find fault with this effort—which may be the reason it is the union’s first high-profile platform issue. It is family-friendly and is an issue that politicians and potential union members can get behind.
Masters of the Influence Universe

SEIU is masterful at using its large base—with almost two million members, it is the fastest growing union in North America—to wield influence. Currently, it is using the promise of millions of union voters to gain the cooperation of presidential candidates and garner media attention. (By law, unions like the SEIU cannot use dues to fund political activities or make donations to candidates for federal, state, or local office. SEIU runs its political activities through a voluntary political action committee, the Committee on Political Education, or COPE. Having employers deduct employee contributions to COPE is a major topic of discussion in bargaining sessions involving SEIU-represented employees across the country.)

Democratic presidential candidates Hillary Clinton, Barack Obama, John Edwards, Christopher Dodd, Bill Richardson, and Joseph Biden, and Republican candidate Michael Huckabee all have participated in or are scheduled to take part in SEIU's “Walk a Day in My Shoes” campaign—a prerequisite to being considered for SEIU endorsement. Senator Clinton joined an SEIU member, a registered nurse, on her hospital rounds in Henderson, Nevada. Senator Obama joined a home health care worker in her client’s home. These events are media magnets that give the union great exposure and status.

“The SEIU is growing stronger and stronger,” says Jackson Lewis attorney Howard M. Bloom. “They've got organizing clout, they've got monetary clout, and they've got political clout.”

Speaking about the Walk a Day in My Shoes campaign and other SEIU strategies, Bloom explains, “They are trying to make themselves look more mainstream and fend off criticism that they are just out for themselves, a negative influence, and that they are out of touch with most Americans. They’ve aligned themselves with AARP, Intel, and others to gain credibility, and now they are aligning themselves with the presidential candidates.”

The candidate who ultimately receives SEIU endorsement will have to sign on to its platform, which includes:

- a national system of universal health care coverage financed by employers, government, and individuals;
- higher minimum nurse staffing guidelines;
- legislation that positions RNs as key decision-makers; and
- comprehensive training programs jointly administered by unions, providers, and schools.

SEIU’s clout was evidenced in Massachusetts recently. The state legislature passed a special bill paving the way for an election among more than 20,000 independent home care workers to decide whether they want to be represented by SEIU. The law not only required SEIU to obtain 10 percent “showing of interest” (rather than the usual 30 percent), but also placed responsibility for conducting the election in the hands of the American Arbitration Association (rather than the Massachusetts Labor Relations Commission) to ensure a quicker election than normal.

Bargaining at Risk

Unionized health care employers hoping for swift, nonconfrontational contract talks next year may need to prepare for disappointment: SEIU is planning the largest coordinated bargaining campaign in health care industry history. During 2008, union contracts with more than 200 hospitals and senior care facilities employing more than 150,000 unionized employees will expire. For the first time, health care workers from SEIU locals in California, Oregon, Washington, Nevada, Minnesota, and Connecticut plan to coordinate their bargaining campaigns in order to maximize their leverage at the table. The SEIU will be able to use the pressure of numbers to force concessions from owners in such areas as wages, benefits, hours, staffing ratios, and mandated training.

Some Good News for Employers

Despite the unions’ increasing clout, Senate Republicans were able to kill the so-called “card check” bill, also known as the Employee Free Choice Act. Had the legislation passed, labor unions would have succeeded in ending 70 years of National Labor Relations Board supervision of secret ballot elections. Unions would have been permitted to establish bargaining rights through the submission of petitions or union authorization cards signed by a majority of employees. Employers presented with enough cards would no longer have been able to remain union-free by prevailing in NLRB-supervised secret ballot elections. We expect that the drive to authorize card checks as a basis for NLRB certifications will gain momentum following the 2008 elections, if not before.

What Employers Should Do

If your organization is not yet unionized, it is more important than ever to be alert to the warning signs that your employees are being targeted by SEIU or other unions. Your Jackson Lewis attorney can help you prepare your supervisors and your facility to recognize these signs, to understand what to do today to remain union-free (including how to become “issue-free”) and to withstand possible “corporate campaign” tactics.
Safety Compliance
OSHA Issues Pandemic Flu Guidance for Health Care

Should a pandemic flu strike, health care facilities will be hit hard by an influx of sick patients. Employees will be at great risk of illness, endangering their own lives and their ability to provide needed care. To facilitate preparation for a pandemic, OSHA has issued guidelines geared to the special needs of the health care industry.

A flu pandemic occurs when a new influenza virus emerges for which people have little or no immunity, and for which there is no vaccine. The disease spreads easily and causes serious illness. It can sweep across the country and around the world in a very short time. Public health experts warn that a pandemic will have global reach and lead to high levels of illness, death, social disruption, and economic loss. A substantial percentage of the population will require some form of medical care, quickly overwhelming the health care system. The scenario includes hundreds of thousands of newly sick patients and decreased numbers of health care workers available to care for them, further burdening a system that struggles to have enough staff to meet everyday needs.

The diversity among health care workers and their workplaces makes preparation and response to a pandemic influenza especially challenging—but it’s critical for health care organizations to prepare themselves for a pandemic scenario. To help make the job of preparation a little easier, the Occupational Health and Safety Administration (OSHA) has prepared a comprehensive document geared to the needs of health care employers and employees.

The guidance, Pandemic Influenza Preparedness and Response Guidance for Healthcare Workers and Healthcare Employers, is organized into four comprehensive sections:

- Clinical background information on influenza
- Infection control
- Pandemic influenza preparedness
- OSHA standards of special importance

Topic areas include:

- Training, vaccination, and personal protective equipment for staff
- Planning and supply checklists
- Risk communication
- Self-triage
- Home care resources
- Diagnosis and treatment of staff during a pandemic
- Internet resources
- Communication tools

The guidance also contains samples of infection control plans, examples of practical pandemic planning tools, and additional technical information. It is available online at www.osha.gov/Publications/OSHA_pandemic_health.pdf.

What Health Care Employers Should Do Now

It is highly recommended that all health care organizations begin to prepare for what most experts consider inevitable. Health care employers will face numerous HR, safety, and employment law issues while planning for pandemic influenza responses. For example, not only must your plans include community responses but also you must provide for the health, safety, and compensation concerns of workers during a time frame that OSHA estimates could last from 12-24 months. Jackson Lewis attorneys are ready to help you make sure you are covering all your preparation bases. Speak with your regular Jackson Lewis attorney, who can help you with questions or concerns, or contact Attorney Frank Alvarez at alvarezf@jacksonlewis.com.

Health Care Industry Compliance Assistance Web Module

OSHA has added a new module to its compliance assistance website. The new Health Care Industry Quick Start module is directed primarily at small employers in the health care field. The module is designed to help users find free resources on the OSHA website related to the health care industry.

The module is made up of eight steps, including OSHA requirements that apply to many health care employers for developing a comprehensive safety and health program, training employees, and recordkeeping, reporting and posting requirements. The new module can be accessed online at www.osha.gov/dcsp/compliance_assistance/quickstarts/health_care/index_hc.html.

The module offers quick help for standard OSHA questions. For answers to unique or complex workplace safety questions, contact the Jackson Lewis attorney with whom you regularly work or Attorney Roger Kaplan at (631) 247-4611, kaplanr@jacksonlewis.com.

The attorneys in Jackson Lewis’ Workplace Safety group have experience at the national and regional levels to help audit your workplace for OSHA compliance; assess and counsel employers on OSHA citations; contest citations; and, where appropriate, negotiate settlement agreements with OSHA or the Solicitor of Labor.
B ringing to a close almost five years of litigation, a unanimous Supreme Court has held that home health aides and other companions employed by third parties are not eligible for overtime compensation under federal law. In its decision, the Court upheld a longstanding interpretation of the U.S. Department of Labor (DOL).

**Facts of the Case:** Evelyn Coke, a former home-health care attendant in New York who was employed by Long Island Care at Home, challenged a DOL regulation, arguing that the DOL improperly extended the statutory exemption concerning overtime pay under the Fair Labor Standards Act (FLSA) to companionship workers who are employed by “third parties” – an employer or agency other than the family or household who is actually using their services (such as Long Island Care at Home). (Ms. Coke’s suit was funded by the SEIU.) In 2004, the U.S. Court of Appeals in New York, in Long Island Care at Home Ltd. v. Coke, found in favor of Ms. Coke. Thereafter, the former employer obtained review by the Supreme Court, which sent the case back to the Second Circuit for further analysis and consideration of a new DOL “Advisory Memorandum” explaining the regulation. The Second Circuit, however, did not change its position and the matter returned to the Supreme Court for ultimate resolution.

**Supreme Court Decision:** Justice Breyer, writing for the Court, stated that the DOL regulation was within the scope of DOL’s rulemaking authority. The Court noted that even though the disputed regulation was “interpretive,” the DOL promulgated it in the same manner as it would have done for a general regulation—through notice and comment rulemaking—and judicial deference to the interpretation was appropriate. The Court explained that while this interpretive regulation conflicts with a general regulation limiting “domestic service employment” to direct employment, the primary focus of the general regulation was on the kind of work performed by domestic service employees, while the “sole purpose” of the interpretive regulation is “to explain how the companionship services exemption applies to persons employed by third-party entities.”

**Good News for Employers:** The Supreme Court’s ruling avoids the prospect of significantly higher wage costs for agencies providing home health care aides and companions in many cases.

For further information about the Supreme Court’s decision and other issues under federal and state laws relating to employee wages, please contact the Jackson Lewis attorney with whom you regularly work or Paul Siegel at (631) 247-4605 of our Wage and Hour Compliance practice group.

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**Pending Legislation**

**Health Information Privacy and Security Act**

Senators Patrick Leahy (D-Vt.) and Edward Kennedy (D-Mass.) have introduced legislation that would create new requirements for handling personal health information (PHI) under the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rules. The bill would give individuals the power to decide when and to whom their PHI is disclosed. The bill is specifically designed to target privacy breaches that have occurred concerning electronic health records, digital databases, and the Internet. Key provisions of the proposed legislation include the following:

- Individuals have the right to inspect and copy their own health records and to receive notice of the privacy rights and practices of data brokers and others who store PHI in electronic databases.
- Data brokers must establish safeguards to secure PHI from data security breaches and other unauthorized disclosures.
- PHI must not be disclosed or used without a patient’s authorization.
- PHI intended to be used for medical research must first be stripped of personally identifying information.
- Patients must be notified of a data security breach involving their PHI within 15 days of discovery of the breach.
- Health care providers are allowed to disclose PHI to law enforcement for legitimate purposes and to a patient’s next of kin, provided that the patient has been notified of the right to object to such disclosure.
Implications for Health Care Entities:
The bill makes it a federal crime to knowingly and intentionally disclose or use PHI without an individual’s consent. Violators are subject to a criminal penalty of up to $500,000 and up to 10 years in prison if the violation is committed with the intent to sell or use PHI for economic gain. Civil penalties will also be assessed against entities that fail to adequately safeguard electronic health records, or to provide consumers with information about their health privacy rights. The proposed bill adds yet another level of bureaucracy: a national office of health information privacy within the Department of Health and Human Services (HHS). Finally, HHS would be required to revise HIPAA’s Privacy Rules.

Patient Safety and Abuse Prevention Act

A bipartisan group of Senators, including Hillary Clinton (D-N.Y.), Pete Domenici (R-N. Mex.), Herb Kohl (D-Wis.), Carl Levin (D-Mich.), Blanche Lincoln (D-Ark.), Claire McCaskill (D-Miss.), and Debbie Stabenow (D-Mich.), have introduced a bill that would create a nationwide system of background checks for long-term care workers.

The bill calls for the expansion of a pilot program that Congress enacted as part of the Medicare Modernization Act of 2003 (MMA). Under the MMA, the Centers for Medicare and Medicaid Services (CMS) has been conducting a pilot program in seven states (Alaska, Idaho, Illinois, Michigan, Nevada, New Mexico, and Wisconsin) to screen out certain applicants for employment in long-term care facilities. Applicants excluded are those whose backgrounds include findings of substantiated abuse and/or a serious criminal history.

Under the current law in 41 states, a criminal background check of some variety is required for long-term care workers. Under present federal law, providers must search any available registry that is likely to contain disqualifying information about an applicant. The CMS pilot states have integrated their systems to coordinate these checks in a single process and have added a federal background check through the FBI’s Integrated Automated Fingerprint Identification System.

The proposed legislation would expand the program to all states, with “limited” federal funding.

Implications for Health Care Employers: The proposed legislation requires that skilled nursing facilities, nursing facilities, and other long-term care facilities and providers conduct screening, including national criminal history background checks, of direct patient access employees, and forbids these employers from hiring workers with abusive histories. Employers faced with this additional burden may find they have access to increased resources if the legislation works as intended and states receive adequate funding. If the system works correctly, employers would also receive information from law enforcement when a direct patient access employee is convicted of a crime. Following the initial national criminal history background check, and if the convicted employee’s fingerprint matches the prints on file with the FBI, the FBI would inform state law enforcement, which would then inform the employer of the conviction. If this legislation becomes law, covered employers will need to update their hiring procedures and policy manuals to address the new requirements.

Safe Nursing and Patient Care Act

U.S. Representatives Pete Stark (D-Cal.) and Steven LaTourette (R-Ohio) have introduced a bill that would strictly limit forced overtime for nurses. Not surprisingly, the legislation is endorsed by the major unions representing nurses, including SEIU. The Safe Nursing and Patient Care Act, which would not apply to nursing homes, would strictly limit the use of mandatory overtime for nurses to situations in which an official state of emergency is declared by federal, state, or local government.

Mandatory overtime limitations would prohibit requirements that a nurse work in excess of 12 hours in a 24-hour period, or 80 hours in a consecutive 14-day period. Voluntary overtime would not be affected. Medicare’s provider agreements would be amended to prohibit the use of mandatory overtime for nurses, except in the case of a declared state of emergency.

The bill prohibits employers from penalizing, discriminating, or retaliating in any manner against nurses who avail themselves of its protections. Employers would be required to post the regulations, to post nurse schedules in a prominent location, and to make daily schedules available upon request.

Implications for Health Care Employers: Employers found in violation may be fined up to $10,000 for knowing violations, which would increase for repeated violations.

Staff shortages resulting from labor disputes or consistent understaffing in a facility are not considered emergency situations, and employers would not be able to require nurses to work overtime in order to ensure mandated staffing ratios.
Jackson Lewis Announces Opening of New Philadelphia Office

Jackson Lewis is pleased to announce the opening of its new Philadelphia office with three partners: Rick Grimaldi, Maria L. Petrillo, and Robert C. Seiger, III. The office is located at 1601 Cherry Street, Philadelphia, PA 19102. The opening of the Philadelphia office marks the seventh new location for Jackson Lewis in the past twelve months.

“Jackson Lewis’ continuing expansion is a direct result of client demand,” says Patrick L. Vaccaro, firm-wide managing partner. “We have always had a very robust client base and practice in the Philadelphia area but the one missing ingredient was a physical presence. With Rick, Maria, and Robert we have significant talent ‘on the ground’ to not only assist us in servicing our current client base but to help us expand into new opportunities and markets. Philadelphia is a great city and the region is well suited for our style of practice.”

The firm’s Philadelphia office will handle all aspects of workplace law, representing management exclusively. This includes litigation, labor relations and preventive practices, immigration, restrictive covenants and wage/hour issues. Jackson Lewis has many specialized practice groups including benefits, affirmative action compliance, disability management, and drug testing and substance abuse management which will enhance the scope of services the new office is able to offer their clients.