ARE YOU READY FOR HIPAA?
Thomas William Baker
(404) 885-3198
tom.baker@troutmansanders.com

All health care providers, and all other persons and entities that gain access to the individually identifiable health information of the provider’s patients, need to have their HIPAA compliance plan in place now. In recent surveys, providers place HIPAA compliance as their number one regulatory compliance priority.

What is HIPAA? “HIPAA” is an acronym for the Health Insurance Portability and Accountability Act of 1996, a sweeping act that included not only provisions related to the portability of health insurance but also fraud and abuse and health care information privacy and security. When used in the current vernacular, “HIPAA” refers to the standards found in the law and regulations governing health information privacy and security.

What Areas of HIPAA Compliance Are Important Today? There are three components of current compliance efforts: electronic data transactions; privacy of individually identifiable health information; and security. To date, the Department of Health and Human Services (DHHS) has promulgated final regulations governing electronic data transactions and privacy. The electronic data transaction regulations become effective on October 16, 2002, and the privacy regulations become effective on April 13, 2003. The industry is awaiting the promulgation of final security regulations.

Weren’t the HIPAA Regulations Delayed By a Year? No, the regulations have not been delayed. Compliance with the electronic data transaction and privacy regulations will require immediate action by all providers and the entities with which they share a patient’s health information.

How Do I Comply With the Data Transaction Regulations? The electronic data transaction regulations establish standard transaction code sets, and these transaction codes must be embodied in the technology used to transmit electronic transactions. As of October 16, 2002, electronic transactions must conform with the standard code sets UNLESS the provider requests a one-year extension on a form that is accessible on the DHHS Web site.

How Do the Privacy Regulations Work? The privacy regulations create a complex system for the maintenance and dissemination of “protected health information” or “PHI.” It is an entirely new system of rights for patients to inspect, copy, amend, and account for disclosures of their health information, and it also regulates relationships with third parties with whom the provider shares PHI, such as billing companies.

There are several different types of permitted uses and disclosures of PHI, including required disclosures (such as the request of a patient), disclosures for

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treatment, payment, or operational purposes with the patient’s consent, disclosures for limited purposes with the patient’s authorization, and other disclosures required by law (such as a subpoena).

The regulations also require providers to self-regulate their relationships with the persons or entities with which they share PHI, defined under the regulations as “Business Associates.” Examples of Business Associates include billing companies, consultants, accountants, transcription services, records management companies, and even attorneys. Each Business Associate contract must include provisions expressly required under the regulations.

What Happens If I Fail to Comply With the HIPAA Regulations? The stakes of non-compliance are very high, including both fines and imprisonment. Criminal liability could include employee liability for an employee’s own conduct, an employer’s liability for an employee’s conduct, a HIPAA privacy officer’s liability for failure to implement, monitor, and evaluate an effective compliance program, and provider liability for acts of its Business Associates. The biggest penalties arise from use of PHI for an entity’s independent commercial gain.

How Do I Comply With the HIPAA Regulations? Compliance with the transactions code sets and privacy regulations will require a comprehensive team effort. The compliance team should consist of the following: your legal counsel, who can advise you on the requirements imposed by law; provider representatives, who will be responsible for doing the detailed work necessary to determine any potential compliance deficiencies; and information technology experts, who can advise the provider regarding technical compliance with the transactions code sets and will likely be involved in compliance with the coming security regulations.

At a minimum, every provider should be undertaking the following actions:

Develop a HIPAA Implementation Work Plan.

Appoint HIPAA Officers and Committees.

Consider Requesting an Extension for the Transaction Code Sets Regulations.

Establish Policies and Procedures for HIPAA Compliance.

Develop the Forms and Documents Necessary to Implement the Privacy Standards.

Train Your Staff in HIPAA Compliance.

Develop Procedures to Mitigate Violations.

Establish “Business Associate” Relationships.

HIPAA compliance starts with a detailed self assessment to determine deficiencies in regulatory compliance within the framework of the law and regulations. If you would like further information and educational materials regarding HIPAA compliance, please contact us. ◆

WHAT FOR-PROFIT HEALTH CARE PROVIDERS NEED TO KNOW ABOUT THE INTERMEDIATE SANCTION RULES

Joseph C. Mandarino
(404) 885-3276
joseph.mandarino@troutmansanders.com

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Most for-profit health care organizations are probably vaguely aware that in 1996 Congress enacted legislation to provide for “intermediate sanctions” against tax-exempt organizations.
While these rules are of great importance to tax-exempts, few attorneys understand that these rules have potentially greater consequences for for-profit health care providers such as doctors, hospitals, ancillary service providers, and others that do business with tax-exempts.

This article outlines the main consequences of these rules from the perspective of for-profit providers, and develops a transactional checklist.

Background

The intermediate sanction rules are in Section 4958 of the Internal Revenue Code (the “Code”) and in the tax regulations promulgated thereunder. (On January 22, 2002, the IRS finalized these regulations.)

The purpose behind Section 4958 is to discourage transactions by tax-exempt entities and certain for-profit entities in which the consideration does not reflect fair market value (FMV). The rules accomplish this by imposing penalties on certain types of transactions between exempt organizations and for-profit organizations. Interestingly, none of the penalties fall on the exempt organization itself, although a tax is imposed on the tax-exempt’s management, equal to the lesser of 10% or $10,000.

However, a significant two-tier penalty tax is imposed on the for-profit party. First, an initial 25% tax is imposed. The for-profit organization then has a specified period to remedy the transaction. In general, a transaction can be remedied if the for-profit party transfers enough cash or property to the tax-exempt party to make up for the less-than-FMV consideration it paid to the tax-exempt. In addition, unless the parties desire to terminate the arrangement, the consideration going forward will have to be adjusted to reflect FMV. If the transaction is not remedied, then a second tax, equal to 200% is imposed. Because this second tax will be double what the for-profit would have to pay if it simply corrected the transaction, the practical result is that a for-profit will be forced to correct the transaction if the IRS succeeds in imposing the 25% tax.

Thus, the two main consequences of running afoul of Section 4958 are (i) a for-profit may be required to pay an amount equal to the spread between FMV and the actual consideration paid, (ii) the for-profit will be liable for a 25% tax on this payment, and (iii) the arrangement will have to be re-priced to reflect this FMV going forward (or will be terminated).

However, Section 4958 will only apply if all three of the following elements are present:

1. an “applicable tax-exempt organization”
2. and a “disqualified person”
3. enter into an “excess benefit transaction.”

Parts 1, 2, and 3 of this article address these defined terms. Failing to satisfy any of these conditions means Section 4958 will not apply. In addition, even if all three conditions are satisfied, the tax regulations provide that a “rebuttable presumption of reasonableness” can arise in certain circumstances. Part 4 discusses how to establish this presumption. Finally, part 5 discusses a risk posed by abusive use of Section 4958.

1. Applicable Tax-Exempt Organization

As noted, the intermediate sanction rules only apply if one of the parties is an “applicable tax-exempt organization.” Therefore, for-profit firms should determine whether the other party to the transaction fits within this definition, an inquiry that is not always obvious.

Section 4958(e) and the applicable tax regulations set forth a complex definition for “applicable tax-exempt organization,” and several exclusions. There are three general categories of organizations that

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satisfy the definition. However, the rules also set forth three exclusions that trump the general categories.

Category 1: Current 501(c)(3) and (c)(4) Organizations

The first category is relatively straightforward: an organization currently exempt under Section 501(c)(3) or (c)(4). In most cases, a Section 501(c)(3) organization is required to apply for tax-exempt status, and its status can easily be researched. Certain types of Section 501(c)(3) organizations, such as religious organizations, do not have to apply, and it may be more difficult to research whether they fall into this category. However, the fact would show up in a review of the organization’s tax returns.

Section 501(c)(4) organizations present more difficulties. Generally such organizations are not required to file a tax exemption application with the IRS. Therefore, the rules provide that this category includes any exempt organization that: (i) has formally applied for recognition under Section 501(c)(4), (ii) has filed tax documents as a 501(c)(4) organization, or (iii) has merely held itself out as a Section 501(c)(4) organization.

A further complication is that many organizations that could be exempt under 501(c)(4) may also qualify for exemption under 501(c)(6). Note that while (c)(3) and (c)(4) organizations are subject to the intermediate sanction rules, (c)(6)’s are not. Therefore, if a for-profit is considering a significant transaction with an organization that could qualify under either (c)(4) or (c)(6), a useful planning tool would be to condition the closing on the organization’s filing for and receiving tax exemption under Section 501(c)(6). Caveat: if the organization had held itself out as a (c)(4) in the past, it is not clear that this strategy would work.

Category 2: Organizations that Were Exempt in the Last Five Years

The second category is also somewhat straightforward: any organization that would have been within Category 1 at any time during the five-year period ending on the date of the transaction. Thus, if a Section 501(c)(3) organization lost its tax-exempt status three years ago, then it would still be treated as an applicable tax-exemption organization.

Note that an excess benefit transaction “occurs” on the date on which the excess economic benefit is received by the for-profit party. This may occur sometime after the execution of a contract. To be cautious, the for-profit should treat the five-year look back period as ending on the date of contract formation.

Unfortunately, it is difficult to research whether a currently taxable company was previously a tax-exempt entity. However, the fact should show up in a review of the company’s tax returns.

Category 3: Organizations that Lost Their Exemption Because of Inurement or Excess Benefit Transactions

The third category is a trap for the unwary. The rules provide that an organization that would be described in Category 1 but for the fact that its exempt status was revoked due to participation in inurement or an excess benefit transaction is always treated as an applicable tax-exempt organization. Accordingly, doing business with a corporation that now appears to be a regular for-profit entity, but which was in fact exempt several decades ago, could trigger the application of Section 4958.

For example, if a Section 501(c)(3) hospital lost its tax-exempt status forty years ago because of political activities, then it would not be treated as an applicable tax-exemption organization and no transactions
with such a hospital could be subject to penalty taxes. However, if the hospital lost its tax-exempt status because of inurement or an excess benefit transaction, then the hospital will always be treated as an applicable tax-exempt organization.

Again, it may be difficult to research whether a currently taxable company was previously tax-exempt, and is even more difficult to determine how such a company lost its exempt status. Reviewing old tax returns may be reasonable for the five-year look back period of Category 2, but may be more difficult in this situation.

It has been suggested that this risk could be mitigated by a representation in the transaction documents to the effect that the counter party is not currently, never has been, and has never held itself out as, exempt under Sections 501(c)(3) or (c)(4). While such a representation would be helpful in flushing out this datum, a breach of such a representation may not yield a remedy. Recall that the purpose of Section 4958 is to penalize and cause the correction of certain types of transactions. Yet if a former exempt organization breached this representation, it would follow that it would be liable for any taxes imposed on the other party and for any amounts paid to “correct” the transaction. Query whether a court would consider enforcing such a remedy as against public policy. Ideally, the IRS will clarify that a reasonable effort to ascertain whether a counter party is an “applicable tax-exempt organization” is sufficient to defeat liability under Section 4958 if the counter party breaches a representation such as the one set forth above.

Exclusions: Private Foundations, Governmental Entities and Certain Foreign Organizations

The rules set out three types of organizations that are excluded from the operation of Section 4958, even if they are otherwise described in the foregoing three categories. The three types of organizations are as follows:

- a private foundation
- a governmental entity that is exempt from tax under a provision other than Section 501(a)
- a foreign organization, recognized by the IRS or by treaty, that receives substantially all of its support from non-U.S. sources

The second exclusion is likely to be most commonly used. It would include any governmental entity that voluntarily applied for a determination of its Section 501(c)(3) status. Because many municipal and county hospitals that were already exempt under Section 115 have also applied for recognition under Section 501(c)(3), this provision effectively excludes them from Section 4958.

2. Disqualified Person

A for-profit company will only be subject to the penalty taxes of Section 4958 if it is a “disqualified person.” Generally, a disqualified person is any person who was in a position to exercise substantial influence over the affairs of an applicable tax-exempt organization at any time during the five-year period ending on the date of the transaction.

The rules on whether an individual or entity is a disqualified person set forth two “per se” tests and one “facts-and-circumstances” test. In addition, there are three exceptions to the factual test (which, confusingly, do not apply to the per se tests). Accordingly, the steps in the analysis are as follows:

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The following paragraphs trace the steps outlined on this previous page.

**Per Se Test #1:** Persons Deemed to Have Substantial Influence Because of Powers

The regulations provide that persons who hold certain powers or positions within an organization are deemed to have substantial influence over that organization. These positions and powers are as follows:

- Any individual serving on the governing body of the organization who is entitled to vote on any matter over which the governing body has authority.
- Presidents, chief executive officers, or chief operating officers (and any person who, regardless of title, has ultimate responsibility for implementing the decisions of the governing body or for supervising the management, administration, or operation of the organization).
- Treasurers and chief financial officers (and any person who, regardless of title,
has ultimate responsibility for managing the finances of the organization).

• Persons with a material financial interest in a “provider-sponsored organization” (as defined in Section 1855(e) of the Social Security Act, 42 U.S.C. 1395w-25).

Per Se Test #2: Persons Related to Disqualified Persons

The regulations provide that persons in certain relationships to disqualified persons are deemed to be disqualified persons. These relationships are as follows:

• The following family members of disqualified persons:
  • spouse,
  • brothers or sisters (by whole or half blood),
  • spouses of brothers or sisters (by whole or half blood),
  • ancestors,
  • children,
  • grandchildren,
  • great grandchildren, and
  • spouses of children, grandchildren, and great grandchildren

• The following entities owned by disqualified persons:
  • A corporation in which disqualified persons own more than 35% of the combined voting power
  • A partnership in which disqualified persons own more than 35% of the profits interest
  • A trust or estate in which disqualified persons own more than 35% of the beneficial interest

Note that for purposes of the 35% controlled entity rule, special constructive ownership rules apply.

Factual Test

As noted, if a person is not automatically treated as a disqualified person under the foregoing two tests, then a facts-and-circumstances test applies. The following circumstances tend to indicate that a person has substantial influence over the affairs of an organization:

• The person founded the organization.
• The person is a substantial contributor to the organization.
• The person’s compensation is primarily based on revenues derived from activities of the organization, or of a particular department or function of the organization, that the person controls.
• The person has (or shares) authority to control or determine a substantial portion of the organization’s capital expenditures, operating budget, or compensation for employees.
• The person manages a discrete segment or activity of the organization that represents a substantial portion of the organization.

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The person owns a controlling interest in a corporation, partnership, or trust that is a disqualified person.

The person is a non-stock organization controlled by one or more disqualified persons.

In contrast, the following circumstances tend to indicate that a person does not have substantial influence over the affairs of an organization:

- The person has taken a bona fide vow of poverty as an employee, agent, or on behalf of a religious organization.
- The person is an attorney, accountant, investment manager or like advisor whose sole relationship to the organization is providing professional advice (without having decision-making authority) with respect to transactions from which the person will not economically benefit (aside from customary fees received for the professional advice rendered).
- The direct supervisor of the individual is not a disqualified person.
- The person does not participate in any management decisions affecting the organization as a whole or a discrete segment or activity of the organization that represents a substantial portion of the activities, assets, income, or expenses of the organization, as compared to the organization as a whole.
- Any preferential treatment a person receives based on the size of that person’s contribution is also offered to all other donors making a comparable contribution as part of a solicitation intended to attract a substantial number of contributions.

Exceptions to the Factual Test

Finally, the regulations provide that certain types of persons are deemed not to have substantial influence over an organization, even if they otherwise satisfy the factual test. These exceptions do not apply to the per se tests outlined above.

Note that two of these exceptions apply to tax-exempt organizations and are not therefore likely to be useful to a for-profit entity. However, if a for-profit entity did substantial business with applicable tax-exempt organizations, it may want to consider converting to a Section 501(c)(3) or (c)(4) status. For example, a professional medical corporation could convert to a charitable status and thereby avoid penalty taxes on its dealing with, for instance, a tax-exempt hospital. However, any salaries or other business arrangements between the former owners of the corporation and the newly exempt organization would now become subject to such penalty taxes.

The third exception applies to certain employees of the applicable tax-exempt organization. Specifically, any full- or part-time employee is deemed not to be a disqualified person if he or she meets the following three conditions:

- the person receives economic benefits, directly or indirectly from the organization, of less than the
amount referenced for a highly compensated employee ($90,000 as of 2002);

- the person is not automatically deemed a disqualified person by virtue of either of the per se tests (see above), and
- the person is not a substantial contributor to the organization.

Note that while the income ceiling would appear to exclude most physicians, it could be broad enough for part-time physicians, as well as many types of ancillary service providers. Because this exception only applies to employees, a health care provider who otherwise comes within the exception but is classified as an independent contractor may want to revise his or her arrangements to be treated as an employee.

Other Issues

The rules provide that in case of multiple organizations affiliated by common control or governing documents, the determination of whether a person has substantial influence is made separately for each applicable tax-exempt organization. This rule will tend to increase the chances that a given person will be treated as a disqualified person.

For example, assume a hospital system has several affiliated tax-exempt entities, all under common control. Assume also that a physician has substantial influence over one of these entities, but has no influence over any of the others. If the test applied in the aggregate, then the physician might not be a disqualified person because he or she did not have substantial influence over the system as a whole. By applying the test to each entity, however, the physician will be treated as a disqualified person with respect to the one entity noted.

If a for-profit entity has some contacts with one member of a group of affiliated tax-exempt organizations, it may make sense to carry on any transactions with other members. However, there are special rules which would ignore this arrangement if the nominal contracting party was merely an agent for another member.

Finally, note that the disqualified person test has a five-year look back period. Therefore, it is not enough to establish that a for-profit had no influence over a counter party at the time of the transaction—it must also be shown for the entire five-year period prior to the transaction.

3. Excess Benefit Transaction

General

The third requirement before the penalty taxes of Section 4958 can apply is that the parties enter into an “excess benefit transaction.” In general, this is defined as “any transaction in which an economic benefit is provided by an applicable tax-exempt organization directly or indirectly to or for the use of any disqualified person, and the value of the economic benefit provided exceeds the value of the consideration received for providing the benefit.” In practice, this comes up in four different ways:

- an exempt organization pays more than FMV to buy or rent property from a for-profit
- a for-profit pays less than FMV to buy or rent property from an exempt organization
- an exempt organization pays more than FMV for services provided by a for-profit
- a for-profit pays less than FMV for services provided by an exempt organization

Definition of FMV

Thus, the key inquiry is whether the consideration for the transaction is at FMV. The regulations provide that in the case of property, FMV is the price at which property or the right to use property would change.
hands between a willing buyer and a willing seller, neither being under any compulsion to buy, sell or transfer property or the right to use property, and both having reasonable knowledge of relevant facts. In the case of services, FMV is the amount that would ordinarily be paid for like services by like enterprises (whether taxable or tax-exempt) under like circumstances (i.e., reasonable compensation). This is not particularly trenchant guidance and, as anyone who has endured an audit can attest, it would be unusual for the IRS and a taxpayer to readily agree on the FMV of goods or services. Accordingly, it may be advisable to obtain an appraisal or valuation to determine whether the consideration in the transaction reflects FMV.

Several items covered by the regulations are worth considering. First, special rules apply to defeat attempts to funnel consideration through taxable subsidiaries, or to otherwise avoid penalty taxes by the use of intermediaries and agents. Second, a significant exception applies to “initial contracts” between an exempt organization and a for-profit entity.

**Initial Contract Exception**

In order to fit within the exception, several conditions must be satisfied. First, an “initial contract” means a binding written contract between an applicable tax-exempt organization and a person who was not a disqualified person immediately prior to entering into the contract.

Second, the contract must provide for fixed payments. For these purposes, “fixed payment” means an amount set forth in the contract or determined by a fixed formula, which is to be paid in exchange for specified services or property. If a formula is used, it can incorporate future events or contingencies so long as no person exercises discretion when calculating the amount of a payment or deciding whether to make a payment. A specified event or contingency can include revenues (or other measure) of one or more activities of the tax-exempt organization. However, “fixed payment” does not include any amount paid under a reimbursement (or similar) arrangement where discretion is exercised by any person with respect to the amount of expenses reimbursed.

Third, substantial performance is required. That is, the exception does not apply during any year in which the person fails to substantially perform its obligations under the contract.

Finally, certain actions will cause an initial contract to be treated as a new contract. If a contract provides that it is terminable or subject to cancellation by the applicable tax-exempt organization (other than as a result of a lack of substantial performance) without the other party’s consent and without substantial penalty to the organization, then the contract is treated as a new contract as of the first date on which such termination or cancellation, if made, would be effective. In addition, if the parties agree to a material change to a contract, it is treated as a new contract as of the date the change is effective. For these purposes, a material change includes an extension or renewal of the contract (other than one that results from a person unilaterally exercising an option expressly granted by the contract), or a more than incidental change to any amount payable under the contract.

Accordingly, if a for-profit is about to enter into a significant contract with a tax-exempt and as a result will likely be treated as a disqualified person (say, for instance, a hospital management contract), the parties should seek to come within the initial contract exception. In addition, the parties should consider avoiding terms that would tend to shorten the protection afforded by this exception. Thus, providing the hospital with early termination rights will tend to minimize the effect of this exception. Similarly, incorporating extension and renewal rights in the contract (rather than leaving it to the parties to negotiate in the
future) will also extend the application of the exception. Finally, pay-or-play type payments will be outside the exception. Thus, golden parachute payments will not be within the exception. Coupling such payments with reasonable future consulting obligations, or the like, may be sufficient to come within the exception.

Netting

Note that certain types of non-FMV transactions do not give rise to penalties. Thus, no taxes are implicated if (1) an exempt organization pays less than FMV to buy or rent property from a for-profit entity, (2) a for-profit entity pays more than FMV to buy or rent property from an exempt organization, (3) an exempt organization pays less than FMV for services provided by a for-profit entity, or (4) a for-profit entity pays more than FMV for services provided by an exempt organization. Unfortunately, there is no guidance permitting netting of different transactions so that any penalties would be assessed only on an aggregate basis. However, a for-profit entity involved in many transactions with the same tax-exempt organization may wish to embody these transactions in one contract or under a master agreement.

4. Rebuttable Presumption of Reasonableness

The regulations provide a special presumption that may be helpful in avoiding the penalty taxes of Section 4958. If the conditions discussed below are satisfied, then transaction is presumed to be at fair market value. The IRS can still rebut this presumption, but only if it develops “sufficient contrary evidence to rebut the probative value of the comparability data” relied upon by the tax-exempt organization.

This means that successfully raising the presumption will shift the balance of proof from the taxpayer to the IRS. While the IRS Restructuring and Reform Act of 1998 statutorily shifted the burden of proof from the taxpayer to the IRS in all courts, this shift only applies if several procedural conditions are met, does not appear to apply to a Section 501(c)(4) organization with a net worth in excess of $7 million, and does not apply at the IRS audit or appeals levels. Therefore, it will still generally be desirable to satisfy this presumption.

In order to raise the presumption, the following conditions must be satisfied:

- The transaction was approved by an authorized body (the board of directors or an appropriate committee) composed entirely of individuals who did not have a conflict of interest with respect to the transaction.
- The authorized body obtained and relied upon appropriate data as to comparability prior to approving the transaction.
- The authorized body contemporaneously documented the basis for its approval.

Satisfying the first and third conditions should be relatively straightforward. However the second condition is less clear. The regulations provide that an authorized body has appropriate data as to comparability if, given the knowledge and expertise of its members, it has information sufficient to determine whether the arrangement in its entirety is reasonable and at fair market value.

In the case of compensation, appropriate data as to comparability includes: compensation levels paid by similarly situated organizations (taxable and tax-exempt) for functionally comparable positions, the availability of similar services in the geographic area of the applicable tax-exempt organization, current compensation surveys compiled by independent firms, and actual written offers from similar institutions competing for the services of the disqualified person. In the case of property, appropriate data as to comparability includes: current independent appraisals of the value of all property to be transferred,
and offers received as part of an open and competitive bidding process.

Note that the steps necessary to raise this presumption are within the control of the tax-exempt, not the for-profit entity. However, the chief beneficiary of the presumption is the for-profit entity. Accordingly, the for-profit should insist that all three requirements be satisfied as a condition of closing, and should retain documentation to establish this (copies of minutes, etc.). Splitting the cost of an appraisal or valuation report, if that is necessary, may be reasonable in this situation.

5. Abusive Use of Section 4958

An additional risk posed by the intermediate sanction rules is that an unhappy exempt organization could use them as leverage to renegotiate a contract. For example, assume that an exempt hospital enters into a long-term arrangement for a for-profit management company to operate the hospital. Assume that several years into the relationship, a competing management company offers the hospital better terms. The hospital cannot terminate the contract without significant penalties, so it tries to renegotiate some of the terms. The management company asserts that it has a valid and enforceable contract and will not bend. The hospital then whispers into the ear of the management company that it is now of the view that the consideration does not reflect FMV and, accordingly, it may be bound to notify the IRS. In essence, the hospital can use Section 4958 as a tool to try to void contracts that it is unhappy with.

It is not clear how the management company could protect itself in this hypothetical. As noted, it could obtain a valuation of the consideration at the time the contract is entered into, and could also require the hospital to take the steps necessary to establish the presumption of reasonableness. In addition, it could incorporate in the contract a recital that the parties agree that the consideration reflects FMV, was negotiated at arm’s length, and is supported by a third-party appraisal. In addition, the contract could contain a covenant that the parties will not take any positions inconsistent with the appraisal as to each other or third parties. Finally, the contract could provide for actual or liquidated damages in the event of a breach of this covenant.

As noted above, courts generally do not enforce contract provisions that are contrary to public policy. Therefore, it is not clear whether the covenant can be enforced. Assume that the hospital violates the covenant and brings in the IRS. Assume also that the IRS prevails and assesses penalty taxes. It would seem unlikely that the management company could obtain damages from the hospital. The hospital would point out that the facts established that the original contract violated the law (specifically, Section 4958), and would argue that it should not be penalized for bringing this violation to the attention of the authorities.

Assume, however, that the IRS did not prevail and the management company then sued for damages under the covenant. The result is far from clear, but the hospital could argue that so long as it acted in good faith, awarding damages against the hospital would frustrate the public policy behind Section 4958 and would permit the management company, in essence, to contractually silence the hospital. Of course, threatening to bring in the IRS in order to get changes to an otherwise valid and fair contract would seem to be an excellent example of bad faith. But if the management company could not show bad faith, it is not clear that a court would permit damages in such a situation.

Conclusion

Given the foregoing, for-profit companies should be aware that transactions with parties that are currently, or were formerly, tax-exempt could trigger significant penalties. The checklist that follows summarizes some practical suggestions, but as noted, it may be impossible to completely eliminate this risk.
Check List for For-Profit Entities

1. Applicable Tax-Exempt Organization
   - Representation in the contract. (sample: “X corporation is not currently, has never been, has never filed tax returns or information statements, and has never held itself out as an organization exempt from tax under Section 501(c)(3) or (c)(4) of the Code”)
     - This is primarily intended to elicit discussion of the issue.
     - Enforcement of a remedy for breach of this representation may be contrary to public policy.
   - Research
     - Review organization’s current and past tax returns (five years minimum).
     - Search IRS database
   - Determine if counter party fits one of the exclusions:
     - Private foundation.
     - Governmental entity that is exempt from tax under a provision other than Section 501(a).
     - Foreign organization, recognized by the IRS or by treaty, that receives substantially all of its support from non-U.S. sources.
   - Mitigation:
     - If a for-profit is considering a significant transaction with an organization that could qualify under either 501(c)(4) or (c)(6), condition the closing on the organization’s filing for and receiving tax exemption under Section 501(c)(6).
     - Caveat: if the organization had held itself out as a (c)(4) in the past, it is not clear that this strategy would work.

2. Disqualified Person
   - Per se test #1
     - Directors, presidents, CEOs, COOs, CFO, treasurers, and the like.
     - Persons with a material financial interest in a provider-sponsored organization.
   - Per se test #2
     - Certain family members of disqualified persons.
     - Corporations, partnerships, trusts, and estates in which a disqualified person has a 35% interest.
   - Factual test
     - Weigh pro and con factors.
     - Consider whether exceptions apply.
   - Other issues
     - Affiliated entities — selection of counter party.
     - Five-year look back period.

3. Excess Benefit Transaction
   - Obtain appraisal/valuation to substantiate FMV of consideration
   - Initial contract exception

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Verify lack of disqualified person status currently and for last five years.

Do payments meet “fixed payment” test?

Substantial performance requirement.

Treatment as new contract upon certain events.

Consider:

- Eliminating or moving back unilateral cancellation right
- Incorporating extension and renewal provisions from the outset.
- Netting — consider making multiple arrangements subject to same contract or master agreement.

4. Rebuttable Presumption of Reasonableness

- Make satisfying the presumption a condition of closing.
- Consider sharing the cost of appraisal or valuation.

5. Other

- Incorporate recital that the consideration reflects FMV, was negotiated at arm’s length, and is supported by a third-party appraisal.
- Covenant that neither party will take any position inconsistent with the appraisal as to each other or third parties.
- Provide for actual or liquidated damages for breach of the covenant.

Require that all three conditions for presumption of reasonableness must be satisfied as condition of closing.

FIRST INTERMEDIATE SANCTION CASE DECIDED: BAD NEWS AND GOOD NEWS FOR TAXPAYERS

Joseph C. Mandarino
(404) 885-3276
joseph.mandarino@troutmansanders.com

On May 22, 2002, the United States Tax Court issued its decision in a case involving the conversion of several tax-exempt home health agencies to for-profit status. The case has been eagerly awaited by observers because it is the first decision involving the intermediate sanction rules. (See previous article in this newsletter.)

In the case, members of the Caracci family formed three tax-exempt home health care companies under the “Sta-Home Health Agency” name in the mid-1970’s in Mississippi. Family members served as the principal officers of these organizations. By the 1990’s, the agencies employed over 1,000 people and had a strong reputation in the community. Virtually all the patients were covered by Medicare, and under the reimbursement rules then in effect, the agencies generally ran losses. In 1995, the Caracci family established three for-profit corporations. An appraisal was obtained and the tax-exempt agencies were determined to have a negative fair market value. The exempt organizations then transferred all their assets to the new corporations in exchange solely for the assumption of their liabilities.

The crux of the Tax Court’s opinion was the valuation question and it considered testimony from experts on both sides. Ultimately, the Tax Court found that the assets had a net worth of approximately $5.2
million and imposed a penalty tax equal to 25% of that amount (approximately $1.3 million) on the Caracci’s.

Interestingly, the Caracci’s had obtained an appraisal (as noted) and relied extensively on the advice of attorneys and accountants in structuring the transaction. Although the government originally asserted penalties against the Caracci’s in their capacity as officers of the exempt organizations, they dropped that claim and proceeded against the Caracci’s solely as the purchasers of the assets. Presumably, this was because appraisals and the reliance on professional advice served to insulate the Caracci’s from the “manager” penalties.

The government also sought a 200% “second tier” penalty against the Caracci’s, but the Tax Court found that assertion unripe and essentially invited the Caracci’s to avoid this potentially $10.4 million penalty by transferring the assets back to the original tax-exempt entities.

Finally, the government sought to revoke the tax-exempt status of the agencies that had transferred their assets. The Tax Court refused, noting that one of the policy rationales for intermediate sanctions was, precisely, to impose a penalty on certain transactions rather than the more draconian remedy of total revocation.

The case demonstrates that:

- Managers of tax-exempt health care organizations can successfully avoid penalties by using appraisals and relying on professional advice.
- Tax-exempt organizations are likely to retain their exempt status in an intermediate sanction case.
- For-profit entities involved in business transactions with not-for-profit organizations can suffer significant tax penalties if the IRS determines the transactions did not reflect FMV.
- The Tax Court will scrutinize appraisals thoroughly and disregard conclusions that it feels are defective.
- Although an exempt organization can shield itself from penalties with an appraisal that the court ultimately determines is defective, a for-profit purchaser cannot.

Thus, the entire penalty fell on the for-profit parties, and not on the exempt parties. The accompanying article examines the operation of these rules solely from the perspective of a for-profit party and suggests ways to minimize the risk of intermediate sanction penalties.

TURNING TO ADR FOR HEALTH CARE DISPUTES

Roderick Mathews
(804) 697-1232
roderick.mathews@troutmansanders.com

Managed health care organizations (MCOs) are turning away from the procedural complexity, delay, high cost and relative inflexibility or litigation for dispute resolution. Increasingly, MCOs seek other means of resolving coverage, access and other difficult disputes through alternative dispute resolution (ADR). And well they should. ADR is not only a smart response to persistent public skepticism about the motives and objectives of MCOs, but the use of ADR will enhance public trust in managed care outcomes.

Time is usually of the essence in health care disputes, and unique, custom-made resolutions are often required. The cost and time efficiency, accessibility, confidentiality and flexibility of ADR are particularly attractive when a patient’s health is at risk. At the same time, the cost, delay and complexity of the judicial process are daunting to the uninitiated. So, ADR is user-friendly, fast, simple, relatively inexpensive

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and attractive for patients, their physicians and advocates.

But why should MCOs turn away from their litigation advantage of their greater resources? The reasons lie in the maturity and politicization (the “greening”) of managed health care. Since the 90s, the response by politicians and regulators to public skepticism for managed health care has produced, from state to state, a patchwork quilt of statutory and regulatory dispute process compliance standards.

To make matters worse for MCOs, renewed double-digit inflation, together with the fading enthusiasm for savings by premium payers at the cost of HR trauma, leaves the MCO without the allegiance of the premium payer in political and regulatory encounters. Solvency issues, despite consolidation, related increased scrutiny by regulators, and compliance with claims payment and other standards imposed by independent standards organizations, have made MCO management a more difficult and less profitable task. As MCOs have matured and “greened,” the political and regulatory momentum has shifted in favor of claimants, and MCOs must look for new means of dealing with disputes.

Despite those changes, the basic motives of the MCOs remain the same: limiting access to health care and leveraging patient volume for discounted health care charges. So, dispute is — and will continue to be — inherent and incessant. But why should the maturity and “greening” of their business persuade MCOs to concede their resources advantage in favor of low cost, fast, and fair ADR?

One concrete and compelling reason is the judicial erosion of the ERISA “shield” from certain claims and liabilities. The “shield” has limited beneficiaries of health benefit plans to benefits claims only and has barred “quality of care” related tort and contract claims tried to a jury. It is that safe harbor that is eroded. Now the federal and state courts have recognized that the shield does not isolate MCOs from quality of care claims. And so, while ERISA is alive and well (and Congress still deliberates remedies), MCOs are not immune from such tort or contract claims tried to a jury.

Also persuasive, particularly for any manager of health care that has been caught in the crossfire of public, media, regulatory or political scrutiny, is that the heat of a difficult dispute might be dissipated by referral to ADR for resolution by an independent, trained, knowledgeable, unbiased and neutral third party decision-maker or facilitator.

If that weren’t enough, health policy experts criticize the use of litigation to resolve such disputes because of the apparent disconnect between the win-lose confrontation of the courtroom and the importance of feedback for continuous health care quality improvement that is implicit in less combative ADR process.

Counsel are, of course, familiar with the various forms of ADR, ranging from non-binding fact finding to binding arbitration and all of the variations between. Generally, ADR is a weapon in the arsenal of an attorney who deals with resolution of disputes. Indeed, an attorney’s responsibility (i.e., in Virginia as a matter of professional responsibility) to his client includes advice of the availability of ADR.

Not long ago, ADR for health care disputes was little used. No more. In 2000, 379 cases were filed with the American Arbitration Association for disputes involving not only the managed health care issues of the day such as coverage, access to facilities and treatment, and quality of care, but also such provider-critical issues as hospital privileges. Measured by both numbers of claims and amount in controversy, most disputes related to payments claimed due by providers.

Some of the original influential thinking on the use of ADR for health care disputes is found in the Report of the Joint National Commission on ADR for Health Care Dispute Resolution. A Due Process Protocol for
Mediation and Arbitration of Health Care Disputes.” The Report, published in July 1998, is the work of a unique collaboration among the American Arbitration Association, the American Bar Association, and the American Medical Association. Each has adopted the Report as organization policy. It is divided into three parts: (1) “Fairness Standards for ADR in Managed Health Care;” (2) a useful explanation of the different types of ADR (mediation, arbitration, etc.); and (3) a catalogue of the types of disputes among the various participants in health care delivery for whom ADR might be effective. Those disputes include: medical necessity; access to providers and facilities, procedures, or equipment; reduction or termination of services; coverage; situations requiring early coordination of treatment by various disciplines (medical, social, psychological, legal and ethical); and any situation where the stakes are high or where strong emotions such as distrust or need for retribution are present and time is of the essence.

Although ADR may be helpful to resolve complex technological or scientific issues such as coverage for an experimental treatment or medication, it must be borne in mind that it is not the province of ADR to rewrite the unequivocal terms of an agreement between the parties such as the coverage terms of an insurance or HMO contract.

Other controversial issues include the propriety of pre-dispute binding arbitration agreements (the Report recommends against them), cost allocation, thresholds and parameters, training and knowledge of neutrals, and the use of multi-disciplinary panels such as MDs, lawyers, etc.


Cost and time efficiency, accessibility/user friendliness, confidentiality and flexibility/adaptability are only the best known of the many advantages of ADR for health care disputes. Additional very good reasons to use ADR for health care disputes are that ADR: helps create a level playing field; enhances the reputation of fairness of those besieged by disputes, such as MCOs; presents an attractive alternative to government-mandated and managed independent external appeals; establishes a confidential setting; and, because ADR is voluntary, has a demonstrable effect on the attitude and degree of satisfaction of the parties. ADR satisfies the “day-in-court” need of many disputants and allows for unique solutions that the courts or government are less likely to craft. ADR allows for the preservation of relationships that typically do not survive the confrontation of the courtroom. Also important, the presence of an independent, trained, knowledgeable neutral assures that disposition will not be the effect of a volatile or a less qualified third party decision-maker.

The advantages of ADR are manifest and persuasive, causing MCOs to turn to ADR to resolve their health care disputes.◆

Roderick Mathews is a partner with the Health Care Practice Group of Troutman Sanders LLP and a member of the health care and commercial panels of the American Arbitration Association (AAA). A member of the Joint National Commission on Health Care ADR that the AAA sponsored with the AMA and ABA, he is a Contributing Editor to the Handbook for Health Care ADR (Aspen Publishers, 2000) and author of several articles on health care ADR.
Out & About

Thomas William Baker gave three separate, contemporaneous presentations at the Dixon-Canary Conference in Las Vegas, Nevada and at the Beau Rivage Hotel & Casino, in Biloxi Mississippi on May 2nd and 3rd 2002. The presentations were given to three separate industry segments and were entitled: “Successful PPS Strategies for Home Health Agencies,” “Successful Hospice Strategies,” “A Comprehensive Seminar For Hospice Agencies,” “Update on Fraud & Abuse,” and “Understanding HIPAA.” Tom gave two presentations at each conference, a total of six presentations. The presentations on fraud and abuse and understanding HIPAA were also presented on May 6th and 7th at Embassy Suites O’Hare – Rosemont in Chicago Illinois by Richard Grier. Tom is also co-Chairman of the Georgia Electronic Commerce Association e-Health Working Group, which is developing its Georgia legislative agenda regarding electronic medical records and privacy.

Christine N. Bostick develops and presents an in-depth training program specifically geared to assist medical providers in their preparation for, and compliance with, the new health information privacy law - the Health Insurance Portability and Accountability Act (HIPAA). Chris also assisted in developing a “Speaker’s Bureau” in collaboration with the Medical Society of Virginia and accepts numerous engagements from medical societies around the state to present to physicians on significant issues in the health care industry. In addition, Chris presents continuing medical education classes on HIPAA and compliance for Hospital Medical Staffs throughout Virginia and North Carolina.

Roderick Mathews presently is in talks with the Medical Society of Virginia about developing a model physician-patient agreement to include an arbitration clause, choice of law provision, and termination provisions, etc per research project growing out of Virginia physician’s concerns about being subject to jurisdiction of courts in adjacent states (e.g. W.Va.) for malpractice claims. In addition Roderick is developing a presentation for the annual meeting of the Medical Society of Virginia in November, 2002.

Richard Grier is assisting a local “conversion foundation” in developing and implementing grant making policies and strategies and identifying and implementing effective conflict of interest policies and practices. A “conversion foundation” is a community healthcare foundation that results from the sale of an operating nonprofit hospital. Later this year, Richard will participate as a presenter in two seminars relating to exempt organizations and their operation.

Scott Alton Mills was named Rotarian of the Year by the Rotary Club of Herndon, Virginia. Scott is in the Tyson’s Corner, Virginia, office.