Storm Clouds Rising

By John A. Knapp
Cozen O'Connor

The Office of Inspector General (OIG) of the Department of Health and Human Services has just released a Special Advisory Bulletin targeting questionable contractual “joint ventures.” The OIG cautions health care providers serving Medicare and Medicaid beneficiaries against entering into joint venture arrangements that, in the OIG's view, “reward the provider for improper patient referrals in violation of the federal anti-kickback statute.” In the news release announcing the Special Advisory Bulletin, the OIG noted that the “bulletin focuses on certain complex contractual joint ventures that, at their core, use a combination of 'shell' entities and subcontracting arrangements with freestanding providers of related health services, such as durable medical equipment or home oxygen suppliers, to disguise illegal kickbacks.”

This Special Advisory Bulletin reiterates and expands upon concerns that the OIG first raised in a Special Fraud Alert published in 1989. The OIG believes that these types of arrangements have been proliferating, notwithstanding consistent warnings to the health care provider community that these arrangements raise significant issues under the anti-kickback statute and the Stark Law.

Questionable Contractual Arrangements

The Special Advisory Bulletin identifies suspect joint ventures as having some or all of the following characteristics:

1. The “Owner” is expanding from its existing practice or business into another related business that is dependent on referrals from the Owner's existing practice or business. Examples of problematic arrangements cited are:
   - A hospital establishes a subsidiary to provide DME. The subsidiary enters into a contract with an existing DME supplier to operate the subsidiary and provide it with inventory.
   - A DME company sells nebulizers to federal health care beneficiaries. The DME company forms a mail order pharmacy to provide nebulizer drugs by contracting with an existing mail order pharmacy to run the DME company's pharmacy, including providing personnel, equipment, space, and inventory.
   - A group of nephrologists establishes a company to provide home dialysis supplies to their dialysis patients. The new company contracts with an existing supplier of home dialysis supplies to operate and supply the new company.

2. The Owner contracts with a “Manager/Supplier” which is an existing supplier or provider already engaged in the same line of business as the Owner's new business. Under this contract, the Manager/Supplier provides management services as well as a broad range of other services necessary to run the new business. These typically include providing the inventory, the office and health care personnel, billing services, and necessary office and storage space.

3. The Owner neither operates nor commits substantial capital or re-

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Danger Zone: How to Avoid Losing Your Charitable Real Estate Tax Exemption When You Lease Property

By Stanley J. Parker and Kristi A. Davidson
Buchanan Ingersoll, P.C.

When charitable organizations lease property, parcels that were once tax exempt can easily find their way back onto the tax rolls. A charity will lose all or part of its property tax exemption when it leases property it owns to another entity (whether for-profit, not-for-profit or a charity) unless certain requisites are met. This article discusses the various constitutional and statutory provisions by which charitable organizations must abide when leasing property in order to maintain the full or partial tax exempt status of that property.1

Qualifying as an Institution of Purely Public Charity

The first step to maintaining a real estate tax exemption is ensuring that the lessor/charity itself meets the statutory and constitutional definitions of a charitable organization. In many instances, the lessor/charity has already obtained a real estate tax exemption for its property; if so, it need only ensure that no material changes in organizational structure, compensation packages, and the like have occurred since the exemption was granted. However, when the property has recently been purchased or when the organization has only just been formed, the lessor/charity must first assess, and be able to prove, its status as a charitable organization.

The Pennsylvania Constitution provides the basis for charitable exemptions, declaring that the legislature has the power to exempt from taxation “institutions of purely public charity.”2 In 1985, the Pennsylvania Supreme Court set forth the constitutional definition of a “purely public charity” (commonly referred to as “the HUP test”),3 and in 1997, the Pennsylvania General Assembly passed the Institutions of Purely Public Charity Act (“Act 55”),4 which codified that basic definition. At the same time, however, the legislature rejected certain judicial interpretations of the HUP test and adopted other interpretations. While an exploration of the differences between the HUP test, as judicially interpreted, and Act 55 is beyond the scope of this article, generally speaking both the HUP test and Act 55 require an organization to meet the following five “prongs” or “tests” before qualifying as an institution of purely public charity:

1. the organization must advance a charitable purpose;
2. the organization must donate or render gratuitously a substantial portion of its services;
3. the organization must benefit a substantial and indefinite class of persons who are legitimate subjects of charity;
4. the organization must relieve the government of some of its burden; and
5. the organization must operate entirely free from profit motive.

An organization does not qualify as a purely public charity merely because it is a non-profit entity.5

When an otherwise charitable organization seeks to lease its property, the “free from profit motive” prong is most often implicated. For instance, if the lease arrangement as a whole, including rent, utilities and other services, gives the owner-charity a substantial profit, the owner-charity may fail to satisfy the “free from profit motive” prong, and hence will not be deemed a “purely public charity” entitled to an exemption.

What “Charitable” Property may be Exempted from Property Taxes?

The Pennsylvania Constitution provides that the legislature is allowed to grant exemptions only for those portions of real property owned by a charitable institution that are “actually and regularly used for the purposes of the institution.”6 Thus, property owned by an institution of purely public charity (as defined above) is not always tax exempt.

Further defining the constitutional use requirement, the Pennsylvania General Assembly has enacted two primary provisions under which charitable organizations may claim eligibility for property tax exemptions that they own and lease to a third party: Section 204(a)(9) and Section 204(a)(3) of the General County Assessment Law.7 Section 204(a)(9) ex-

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empts from taxation real property (a) owned by a charity; and (b) used or occupied jointly by the charity and another charity; so long as (c) the real property is necessary for the occupancy and enjoyment of the charities using it. Courts have generally held that in keeping with this provision, the lessee must share in the property’s charitable mission. In contrast, Section 204(a)(3) exempts all “institutions of learning, benevolence, or charity … with the grounds thereto annexed and necessary for the occupancy and enjoyment of the same,” provided that the entire revenue derived from the property is applied to the support, repair and increase of the charity’s charitable mission.8 In contrast, under Section 204(b)(9), the owner/charity then must clear the financial hurdles of both Sections 204(b) and 204(c). Under Section 204(b), the owner/charity must prove: (1) the property is not the source from which any income or revenue is derived; (2) any rent paid to the property is merely nominal; and (3) the lessee receives the benefits of the owner’s charity. An overall lease arrangement can satisfy these requirements even if the rent charged is at or near market rates.9 For instance, in Borough of Homestead v. St. Mary Magdalen Church,10 the court held that the Diocese of Pittsburgh was entitled to a property tax exemption for a building it owned (the Bishop Boyle Center) despite the fact that it used only 5 percent of the Center itself, rented 16 percent of the Center’s space to for-profit entities and 79 percent of the Center’s space to non-profit entities (the lessees). The lessees paid rents to the Diocese that were close to the going commercial rate. The court examined the entire leasing arrangement and found that the fees paid by the lessees were below market value once the costs of the services provided by the Diocese were taken into account, and although some lessees made improvements at their own expense, the court found that they were mostly cosmetic and relatively insubstantial. Moreover, each of the lessees conducted a business that furthered the Diocese’s charitable mission. Based upon these facts, the court concluded that the lessees were recipients of the Diocese’s charity and hence, any income or revenue generated by the lease of a portion of the property did not preclude a continuation of the tax exemption for the entire Bishop Boyle Center.11

In contrast, in Appeal of Archdiocese of Philadelphia,12 the court characterized the lease between the owner charity and another charitable organization as “an arm’s length transaction between landlord and tenant for market value.” In addition to rent, the lessee was responsible for utilities and maintenance and made substantial investments in improvements that reverts to the owner/Archdiocese. Under those circumstances, the lessee could not be described as a recipient of the owner/Archdiocese’s charity. Because the entire property was leased and because the financial and use hurdles had not been cleared, the court declared the entire property taxable.13

The final hurdle for an owner-charity seeking a charitable tax exemption for property it owns but leases to a third party is contained in Section 204(c), which provides that the owner/charity must both occupy the property and have a continuing right of possession and control over the premises. Although courts have not defined “occupied” with particular specificity, it is clear that the term requires the owner/charity to prove that it actually and regularly uses more than a de minimis portion of the property for its own charitable work. Two cases illustrate that minimal use of a building is not enough to prove occupancy. In Archdiocese of Philadelphia, the court held that the owner/charity did not prove use and occupancy merely by parking its bus in a garage on the premises.14 Similarly, in Greater Erie Economic Development Corp. Appeal,15 the owner/charity did not “occupy” the building simply by conducting its board meetings on the premises. Thus, the key to satisfying the financial hurdles of Section 204(b) and the use hurdles of Section 204(c) is carefully crafting and structuring the lease so that a “typical” or “arms-length” landlord/tenant relationship is not created. The following is a list of factors courts have considered when deciding whether an owner/charity has satisfied these hurdles:

- Whether the lease favors the owner/charity;
- Whether the lessee is responsible for paying most or all costs associated with the use of the property;
- Whether the lessee is responsible for maintaining insurance;
- Whether the lessee is responsible for costs pertaining to zoning, use and occupancy permits or licenses;
- Whether the lessee is responsible for the payment of real estate taxes and any other taxes or assessments resulting from the leasing of the facilities;
- Whether the lessee is responsible for the costs of remodeling and any repairs necessary to prepare the premises for occupancy;
- Whether the lessee is responsible for the costs of utilities used on the premises;
- Whether the lessee is responsible for interior and exterior regular maintenance and upkeep, including such things as cutting and trimming the lawn, trees and plants; janitorial service and trash removal, maintenance.

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of pavements and parking area, etc.;
● Whether the lessee must indemnify and defend the lessor from costs and expenses, losses or liabilities arising from occurrences on or about the premises;
● Whether the lessee has the unrestricted right to sublet all or a portion of the property; and
● Whether the annual rent is above, below or at market value. 16

“Splitting the Baby:” Awarding Exempt Status to Part of the Property

Courts have circumvented the sometimes harsh application of the foregoing statutory requirements by “splitting the baby.” For example, in In re Appeal of Sewickley Valley YMCA, 17 the Commonwealth Court affirmed a decision granting tax exempt status to 92 percent of the YMCA’s property (the part used by the YMCA) and denying tax exempt status to the remaining 8 percent of the property, which the YMCA had leased to a third party. Charitable organizations should keep the courts’ power to make these equitable splits in mind.

Who has Standing to Challenge the Denial of an Exemption?

As a final note, it is important to consider what happens when a taxing body challenges the exempt status of charity-owned real estate. In the absence of a lease provision on point, do both the owner/charity and the lessee have standing to champion the exemption? It depends. If the lessee has taken on the characteristics of an “equitable owner,” either the owner/charity or the lessee may pursue the exemption. For example, the Pennsylvania Commonwealth Court recently ruled that when title to the improvements and to the leasehold itself are granted to the lessee during the term of the lease, the lessee has standing to appeal the property’s tax status. 18

Be careful, however; the ability to challenge a taxing authority’s decision regarding an exemption does not equate to eligibility for an exemption. While lessees may be able to champion a real estate tax exemption by virtue of their relationship to the property, exempt status generally cannot be granted on the basis that the lessee (as opposed to the owner/charity) is an institution of purely public charity. 19 Rather, the property generally must be owned by a charity in order to be eligible for real estate tax exemption.

Conclusion: General Principles to Abide by When Structuring a Lease

Exempt status is granted on a case-by-case basis after a complete exploration of the variables at play. However, charitable organizations should keep the following general principles in mind when structuring their lease arrangements: (1) the lessee should share in the owner/charity’s mission and use the property in furtherance of that mission; (2) the overall leasing arrangement should not be profitable: the lease should provide for rent that is at or below market rates, and the owner/charity should be responsible for building maintenance and improvements; and (3) the owner/charity should continue to occupy a portion of the leased property and should maintain its right to continued possession and control of the premises.

Endnotes

1 This article does not, and cannot, substitute for legal advice. As this article attests, maintaining tax exempt status despite a leasing arrangement can be difficult. Accordingly, a charitable organization considering or drafting a lease should consult with counsel first.

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Health Law Institute Celebrates 10th Anniversary

By Ruth M. Siegel and Edward F. Shay

Begun 10 years ago, the Health Law Institute continues to be the one time during the year when anyone who practices in the field of health law has an opportunity to spend a couple of days together to be updated on everything that’s new. Workshops are offered on every conceivable important topic in health law. It’s also a time for veterans in the field to renew friendships with acquaintances and former colleagues. There is always plenty of informal conversation about what has been happening in the business of health care during the past year and reminiscing about “how the practice used to be.” The Health Law Institute is also a terrific way for those newer to the field to gain familiarity with fraud and abuse, physician issues, long term care, managed care, antitrust, HIPAA and all the other legal issues involving health care entities and individuals. And, it’s a great networking opportunity. Nursing home administrators, CPAs and other professionals who work in health care also attend this popular event in addition to lawyers. The Institute has grown in stature and dimension since its inception – more than 500 health law professionals now attend it each year.

The Health Law Institute is presented by the Pennsylvania Bar Institute in cosponsorship with the PBA Health Care Law Committee and other cosponsoring organizations. In 2004, the Health Law Institute will be held in Philadelphia at the Pennsylvania Convention Center on March 17-18. Save the dates and plan on joining us in celebrating our 10th year!

If you have an idea of a topic that you would like to present at the Institute, the PBI would love to hear from you. Just email a one paragraph proposal of your topic, the format for the session and a biographical sketch to PBI Staff Attorney Carolyn L. Wepfer (e-mail: cweper@pbi.org) by the end of July. Even if you are not interested in being a presenter, but have an idea for a topic that you think should be presented at the Institute, please share your idea with Carolyn Wepfer. Also, please share with the PBI any thoughts or suggestions you might have to celebrate the 10th anniversary of the Institute.

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8 See generally Borough of Homestead v. St. Mary Magdalen Church, 798 A.2d 823 (Pa. Commw. 2002) (finding property entitled to exemption even though for-profit entities rented space from the owner charity because they shared in the mission of the owner charity and because they were recipients of the owner's charity due to the fact that the owner provided services to them at a substantial loss).

9 Although note that if an owner charity is trying to qualify for an exemption based on Section 204(a)(3), any surplus revenue derived from rent must be applied to repair, maintenance and improvements for the facility.


11 Id. at 827-28.


13 Id. at 823-24.

14 Id. at 824-26.


16 See, e.g., Appeal of Archdiocese, 617 A.2d at 824-25.


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sources to the new business. Because the success of the new business is substantially dependent on referrals from the Owner’s existing practice or business, there is essentially little or no risk to the Owner.

(4) The Manager/Supplier would, except for the contractual relationship with the Owner, otherwise be a competitor to the new business.

(5) The Owner and the Manager/Supplier share in the economic benefit of the new business.

(6) The aggregate payments to the Manager/Supplier vary with the volume or value of the business generated by the Owner.

These Joint Venture Arrangements May Not Qualify for Safe Harbor Protection

The OIG believes that, while these relationships are often structured in such a way to break the various services provided by the Manager/Supplier into their component parts (e.g. space rental, management services, staffing services, etc.), with each component part intended to qualify for safe harbor protection, such a structure is ineffective in qualifying the joint venture, as a whole, for safe harbor protection for the following reasons:

(7) An essential element in the joint venture is the provision of items or services by the Manager/Supplier to the new business for prices less than the Manager/Supplier generally charges for such items or services when it provides such items or services on its own behalf directly to its patients or customers. This represents a discount in the OIG’s view. Furthermore, this discount does not, in the OIG’s view, qualify for the discount safe harbor because that safe harbor only applies to discounts given in an arm’s-length business relationship, and the OIG does not view dealings between partners in a contractual joint venture of the type described in the Special Advisory Bulletin as being at arm’s-length.

(8) Even if all of the various relationships between the Owner and the Manager/Supplier did fit within one or more safe harbors, the OIG believes that by agreeing to provide to the new business at discounted prices, items or services that it could otherwise provide itself at higher prices, the Manager/Supplier “is providing the Owner with the opportunity to generate a fee and a profit. The opportunity to generate a fee is itself remuneration that may implicate the anti-kickback statute.”

Indicia of a Questionable Contractual Joint Venture

In the Special Advisory Bulletin, the OIG identifies certain characteristics that potentially indicate a prohibited joint venture arrangement, including:

- **New Line of Business.** Typically, the provider is expanding into a new health care service that can be provided to existing patients.
- **Captive Referral Base.** The new business predominantly or exclusively serves the existing patient base.
- **Little or No Bona Fide Business Risk.** The Owner’s primary contribution to the venture is referrals, and it makes little or no investment in the business.
- **Status of the Manager/Supplier.** The Manager/Supplier is a potential competitor of the new line of business and would normally compete for the captive referrals.
- **Scope of Services Provided by the Manager/Supplier.** The Manager/Supplier provides all or many of the key services of the new venture. In general, the greater the scope of services provider by the Manager/Supplier, the greater the likelihood, in the OIG’s view, that the arrangement is a questionable contractual joint venture.

- **Remuneration.** The remuneration from the venture to the Owner takes into account the value and volume of business generated by the Owner.
- **Exclusivity.** A non-compete clause is included in the joint venture contract.

The timing of this Special Advisory Bulletin is not coincidental. The current Inspector General, Janet Rehnquist, has recently been forced to announce her resignation, in part because many legislators and enforcement officials felt that she had been lax in her enforcement of the fraud and abuse laws. Coming as it does in the final days of Rehnquist’s tenure, this Special Advisory Bulletin sends a strong message that the enforcement winds are stiffening and a storm may be on the horizon.

Endnotes

1 The Special Advisory Bulletin is available at http://oig.hhs.gov/fraud/docs/alertsandbulletins/042303SABJointVentures.pdf

Nominations Now Open for the 2003 Excellence in Health Care Law Award

The PBA Health Care Law Committee is seeking nominations for its 2003 “Excellence in Health Care Law Award.” As the name implies, this award is given to a health care law attorney whose expertise and professionalism demonstrate the best of our profession. Nominations must be submitted no later than Dec. 31, 2003.

Fax or e-mail your nomination to:
Paul C. Troy
Fax (610) 275-2018
or ptroy@kanepugh.com
Two recent pronouncements of the Office of Inspector General (OIG), of the Department of Health and Human Services (HHS) and the Centers for Medicare & Medicaid Services (CMS), respectively, underscore the continuing uncertainty with respect to the analysis of compensation arrangements structured on other than a flat fee basis under the Anti-Kickback Law Safe Harbors and the exceptions to the Stark Law. First, on April 3, 2003, the OIG issued Advisory Opinion No.03-8 in which it declined to offer protection from imposition of sanctions under the federal Anti-Kickback Law to the Requester, a management company compensated on a “per patient, per day” basis for services provided to hospitals. Second, on April 25, 2003, CMS announced that it was extending for the third time, until Jan. 7, 2004, any decision regarding the inclusion in the Stark personal services exemption of language dealing with percentage compensation. Both “per patient, per day” and percentage compensation arrangements are widespread in the health care industry.

Advisory Opinion 03-8

In Advisory Opinion 03-8, the OIG determined that the proposed arrangement did not qualify for protection because the aggregate compensation paid by a hospital to the Requester would not be set in advance within the meaning of the personal services and management contract safe harbor, and because the arrangement did not have any other features which would render the risk of overutilization sufficiently low. The requester, a corporation that develops and manages distinct part inpatient rehabilitation units located within general acute care hospitals, proposed to enter into management agreements with general acute care hospitals. The Requester would provide all patient care personnel other than nurses, including a leadership team, a medical director, and marketing services.

Each hospital would pay the requester a monthly management fee that would be calculated on a “per patient per day” basis. Specifically, the management fee would be determined by multiplying a pre-established fixed amount per patient per day by the aggregate number of patient days for all patients receiving care as inpatients in the unit during each month. Each hospital would be responsible for billing and collecting all charges for services rendered in its unit. For the purposes of this analysis, the OIG accepted without question the requester’s certification that the management fee would reflect fair market value.

The requester estimated that approximately 70 percent of the patients in its units would be Medicare beneficiaries. Medicare reimburses inpatient rehabilitation units on a prospective payment system (PPS) basis which requires, among other things, pre-admission screening and that 75 percent of the admissions to the unit be for specific medical conditions such as stroke, spinal cord injury, neurological disorders, and burns.

OIG’s Legal Analysis

The OIG noted that the safe harbor for personal services and management contracts at 42 C.F.R. § 1001.952(d) is potentially applicable to the proposed arrangement. One condition of the personal services and management contract safe harbor is that the aggregate compensation must be set in advance, consistent with fair market value in an arm’s length transaction, and not determined in a manner that takes into account the volume or value of any referrals or business otherwise generated between the parties. In requesting the advisory opinion, the requester acknowledged that the proposed arrangement was not protected under the safe harbor because the aggregate compensation paid by the hospitals to the requester under the management agreement would not be “set in advance,” but would depend on the number of patient days of service. The requester was clearly hoping that the OIG would conclude that the “per patient, per day” management fee would be viewed, in combination with the other elements of the transaction, as providing a sufficient degree of protection against potential overutilization or other abuse.

Significantly, however, the OIG instead reemphasized its position that “per patient,” “per click,” “per order,” and similar payment arrangements with parties in a position directly or indirectly to refer or recommend an item or service payable by a federal health care program are disfavored under the Anti-Kickback Law because such arrangements promote overutilization and unnecessarily lengthy stays. Furthermore, the OIG concluded that the other features of the proposed arrangement did not reduce the risk to a sufficiently low level to allow the OIG to grant protection to the arrangement. In particular, the OIG found that the PPS payment methodology itself did nothing to discourage unnecessary admissions despite its provisions limiting admissions and

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length of stay. In addition, it found that nurses performing the pre-admission screenings and the medical director, a physician in a position to refer, shared common financial and programmatic goals with the requester. The OIG further noted that the requester would also be performing marketing. Finally, while the per-patient per-day fee may be reflective of actual costs incurred, the OIG found that it could also simply cloak a success fee.

Compensation Arrangements Under Stark

The Stark law and regulations also use the term “set in advance,” in setting forth criteria for physician compensation in connection with certain exceptions, to the general prohibition on referrals by physicians who have a financial relationship with a provider of designated health services. With respect to Stark, however, CMS has made it clear, in the context of percentage compensation, that aggregate payment need not be set in advance. However, if the aggregate amount is not specified, the amount of payment on a per use, per service or per time period basis must be fixed in advance. According to the preamble to the Stark II regulation issued January 4, 2001, percentage compensation that is determined by calculating a percentage of a fluctuating or indeterminate amount such as revenues, collections or expenses, is not fixed in advance. In contrast, a percentage of a set fee schedule is considered fixed in advance as long as the parties are operating from a single fixed fee schedule.

Despite the Preamble commentary, it is presently unsettled as to what would constitute a “per use,” “per service” or “per time period” payment amount that is fixed in advance. Subsequent to the promulgation of the first part of the final Stark II regulations, CMS received a great deal of commentary from the health law community that took issue with its interpretation of the statutory and regulatory standard. As many physician contracts with hospitals and other providers have compensation provisions that call for a percentage of revenues or collections, CMS’s interpretation would necessitate a restructuring of many of these agreements. Accordingly, CMS has suspended application of the pertinent language of the regulation three times, and stated that it would address this issue when it promulgated the remaining regulations to be finalized under Stark II. The most recent extension – until Jan. 7, 2004 – was announced on April 25, 2003. CMS reiterated that it will address this issue in the second phase of the Stark II regulations.

Impact of the Advisory Opinion

Providers with existing arrangements that use a “per patient per day,” “per click,” “per order,” or other similar compensation formula for physicians or entities who or which are in a position to influence referrals, may wish to re-examine the structure of their arrangements due to the strong language in the Advisory Opinion disfavoring these types of payment arrangements. Providers should also take note of the various features of the arrangement that were highlighted by the OIG as being insufficient safeguards against overutilization. Clearly, reliance on the disincentives built into the PPS reimbursement methodology is an inadequate safeguard. Some measures that could alleviate the OIG’s concerns include providing for disallowance of management fees based on unfavorable utilization review determinations, adoption of stringent admission criteria, and retention by the provider of all marketing activities.

In addition, the OIG’s strong language disfavoring “per use” or “per service” compensation arrangements is confusing when such an arrangement would be acceptable in the context of the Stark II regulations.

The Anti-Kickback Safe Harbors and the Stark exceptions, while often using similar language, are regulatory provisions that have been promulgated for very different reasons. The Anti-Kickback Safe Harbors offer providers protection from criminal and civil sanctions, but failure to fulfill each and every particular provision of a safe harbor does not necessarily mean that an arrangement violates the Anti-Kickback Law. The Stark exceptions, however, are intended to provide bright line tests that must be met in order to avoid a Stark violation. Furthermore, as a criminal statute, the Anti-Kickback Law requires an examination of intent to determine if it has been violated. Stark is not an intent based statute. Therefore, even though the OIG has taken one approach to interpretation of the phrase “set in advance,” it would not necessarily be inconsistent for CMS to interpret the same phrase to allow compensation based on a percentage of an indeterminate amount for purposes of Stark. Nonetheless, one conclusion is clear. In the face of current uncertainty, great care must be taken in structuring percentage or other variable compensation arrangements, when the party receiving compensation is in a position to make or influence referrals to the party paying the compensation.

(See Recent HHS Statements on page 9)
The Liability Insurance Crisis Facing Long Term Care in Pennsylvania

By Alan G. Rosenbloom

In the last 18 months, we have been inundated with information concerning the medical malpractice liability crisis facing Pennsylvania physicians and the increasing impact it has had on patient access to care. We have heard all too little, however, concerning the impact of the liability crisis across the continuum of long term care and senior service providers – retirement communities, nursing homes, assisted living/personal care homes, home health agencies and other home-and-community-based services.

Liability insurance for long term care providers in Pennsylvania increasingly is unavailable and unaffordable – and now poses a major threat to access to care. In 1999, seven carriers offered professional liability insurance to long term care providers in the state. By 2001, the number had shrunk to four, which dropped to three in 2002. For all practical purposes, two or fewer carriers now appear willing to write new long-term care business here.

In 2001, rates for primary coverage of nursing homes increased by as much as 87 percent, following a 250 percent increase from 1996 to 2000. In each year since, primary premiums have increased by as much as 500 percent for both nursing homes and assisted living residences. In addition, the CAT Fund surcharges and Mcare Fund assessments imposed on nursing homes have skyrocketed. In 2002, for example, CAT Fund surcharges for nursing homes increased by as much as 121 percent throughout Pennsylvania and Mcare surcharges for 2003 increased at least 43 percent for most facilities. Insurance costs on a per-bed basis now hover between $1,250 and $1,500.

Loss experience does not justify such precipitous increases. In 2000, for example, the average non-zero claim against nursing homes in Pennsylvania was $61,000, well below the national average of $246,000 and the $500,00 threshold for CAT Fund attachment. Indeed, over the life of the CAT Fund, nursing home surcharges paid into the CAT Fund exceeded payouts for nursing homes by more than 15 times.

Although factors other than Pennsylvania-specific loss experience are undermining the insurance market, the frail, vulnerable seniors are feeling the impact. In 2002, Temple University closed three nursing facilities in Philadelphia. Press accounts identify liability insurance costs as a key factor in these closures. As a result, some of the city's most frail and vulnerable citizens were relocated from facility to facility, with some transferred as far away as Hazleton. Closures of this kind are traumatic for residents and may well cut them off from family and friends forever.

Any effort to reform the medical malpractice insurance and liability system must address the challenges facing long term care providers as well as doctors and hospitals. To do otherwise courts disaster, as states that offered health care insurance reform exclusively to doctors and hospitals have learned. In Florida, for example, reform legislation in the mid-1990s did not extend to long term care providers. As a result, liability protection now costs as much as $7000 per bed and the state's Medicaid program, which is the largest payer for long term care services in the state, now devotes 30 cents of every state tax dollar devoted to Medicaid on liability-related expenses. Gov. Rendell and the General Assembly would do well to learn the lessons of this cautionary tale and assure that long term care providers receive adequate protection as they craft solutions to the malpractice crisis in the commonwealth.

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The parties should build meaningful controls for overutilization into their business arrangements and memorialize them in their written agreements. In addition, even if these arrangements are properly structured and reviewed at their inception, they should be periodically reevaluated in light of evolving law.
The commercial insurance market is tight. Products are expensive and access is limited. The situation is tough for health care providers, and particularly so in Pennsylvania. While politicians wrangle with various proposals intended to reduce the cost of commercial insurance, many organizations are evaluating alternative insurance vehicles, including “captive” insurance companies.

Captives are closely held insurance companies that provide coverage for and are controlled by their owners (also known as their “parents”). To be worthwhile, captives must provide their parents with control over long-term costs and access to quality insurance. They may also have additional benefits. For example, they may foster the development of comprehensive and strategic risk management/loss control programs. They cannot, however, provide insurance to the uninsurable.

The simple, working definition set forth above belies the complexity of the subject. As always, the devil is in the details. Captives may provide insurance to a single parent, or to multiple parents, or to one or more entities controlled by or affiliated with the parents. Captives may be domiciled in the United States, “onshore,” or in one of several foreign jurisdictions, such as Bermuda or the Cayman Islands, “offshore.” Tax treatment of captive arrangements may vary considerably, depending on factors such as the type of captive, the tax status of the parent or parents, and the actual finances of the captive’s operation.

A captive serving a single parent, often referred to as a “pure” captive, provides insurance to the parent, or in some cases to entities closely related to the parent. The captive may provide this coverage directly, or by reinsuring a primary commercial insurer or “fronting” company.

The offshore single-parent captive has historically provided tax benefits to tax-exempt parents. The two most prevalent domiciles are Bermuda and the Cayman Islands. Neither imposes a corporate income tax. However, an offshore captive is not exempt from taxation in the U.S., even if owned and operated for the benefit of a tax-exempt entity, and must be careful to avoid engaging in U.S. trade or business since that may trigger U.S. federal income tax and perhaps a “branch profits tax.” Parents of offshore captives must also contend with the possibility of federal excise taxes on premiums paid to offshore “insurance companies.”

Onshore single-parent captives may be more attractive to some tax-exempt parents, because such captives may obtain their own tax-exempt status if they cover only their exempt parents and their controlled affiliates. State taxation varies greatly, however, and most states still impose a “self procurement tax” on premiums paid to offshore “insurance companies.”

Onshore reciprocal risk retention groups are another option of interest to some tax-exempt organizations. Reciprocals are taxable entities that qualify as “insurance companies” for tax purposes and are therefore eligible to deduct reserves for future losses. Participating organizations may be linked by a variety of formal or informal means. The Federal Risk Retention Act permits reciprocals to write liability coverage nationally without the need of a “fronting” company.

Each reciprocal maintains a “subscriber savings account” on its own books for each of its participating members. Subject to certain limits, the Code permits Reciprocals to deduct profits allocated to the members’ accounts. Since the members are exempt from taxes, the profits allocated to their respective accounts do not produce taxable income.

Whether onshore or offshore, reciprocals and other multiple-parent captives present unique governance problems that should be carefully addressed in organizational documents. It is also important that members share certain core values, including a commitment to adopt and maintain meaningful loss control programs.

Though not truly captives, “rental captives” and “segregated protected cells” are additional options available to health care providers. Rentals are generally subsidiaries of traditional insurance companies that create separate books for their insureds. Part of the original rationale for this arrangement was that premiums paid by for-profit insureds would be deductible as insurance expenses. However, the IRS has successfully challenged this premise by arguing that without a real transfer of risk, the arrangement is not properly treated as insurance.

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Continuing Care Retirement Communities Should be Wary of Unintended “Contracts” to Admit Applicants

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Long term care facilities, and CCRCs in particular, should be on guard for admission procedures and materials that may inadvertently establish a binding contract with an applicant at a point in time earlier than that contemplated by the facility. A facility that finds itself in such a situation may be bound to provide housing or substantial health care services to an applicant it was not yet expecting to serve.

The basic elements of a contract are an offer, an acceptance of the offer and something of value given to the offeror by the party accepting the offer. Long-term care providers should review their admission materials with these simple contractual elements in mind so that they know exactly when an enforceable contract is formed.

For example, some facilities require that a fee be submitted with the application. The materials should clearly set forth that the application fee is the charge to the applicant to have the application evaluated for possible placement on a waiting list, and does not constitute acceptance of any further offer or otherwise secure any further rights.

Some facilities have long waiting lists and require applicants, at some point, to pay a “priority” fee in addition to the application fee. Often, the facility may request this fee to determine who on their waiting list is “ready” for admission. A CCRC that uses a “priority” fee should review its admission materials to be certain there is no promise of admission if the applicant pays the fee. An applicant should reasonably be able to understand from the materials that this is a nonrefundable fee paid to the facility to further evaluate the applicant. The applicant should be able to understand that other steps await him/her prior to acceptance by the facility. A facility must also be certain that its admission process complies with the provisions of Pennsylvania’s Continuing Care Provider Registration and Disclosure Act.

We suggest that facilities review their current admission materials and pay particular attention to:

- the point in time when an applicant can reasonably believe that he/she is accepted into the facility;
- whether this “point in time” is different from (and, in particular, earlier than) the point contemplated by the facility;
- any required medical assessments (is it clear that a medical assessment is required shortly before admission, and if so, is it clear that this medical assessment is critical to the CCRC’s final “acceptance” of the applicant?);
- financial information requested (particularly whether your material clearly indicates that updated financial information will be requested at various points prior to admission, and that misrepresentation of financial status will void any contract that may subsequently be formed).

Documents must be carefully worded so that even after admission, the facility does not inadvertently breach the contract. For example, the facility may or may not choose to incorporate resident rules and regulations into the resident’s agreement. If incorporated, the rules and regulations become contractual terms binding both the resident and facility. This can, of course, work both ways. The facility must carefully review its rules and regulations to assess whether it wishes to be bound by those rules as soon as the applicant signs the resident’s agreement. This problem may be alleviated somewhat if the facility expressly retains the right to change the rules and regulations at any time and without notice.

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In a segregated protected cell, an existing insurer creates cells within itself, following procedures similar to those required to establish a single-parent captive. Cells are statutorily protected from claims made against the owners of other cells within the sponsored company, a protection not generally available in rental arrangements.

The Final Word

Captives continue to offer advantages to some organizations, especially in light of the current commercial insurance market. Unfortunately, the decision to form or join a captive arrangement involves complex regulatory and financial considerations. Nevertheless, a sound risk-management plan should include an analysis of whether and how an organization may reduce its insurance costs or improve its insurance protection through some type of alternative insurance arrangement.
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