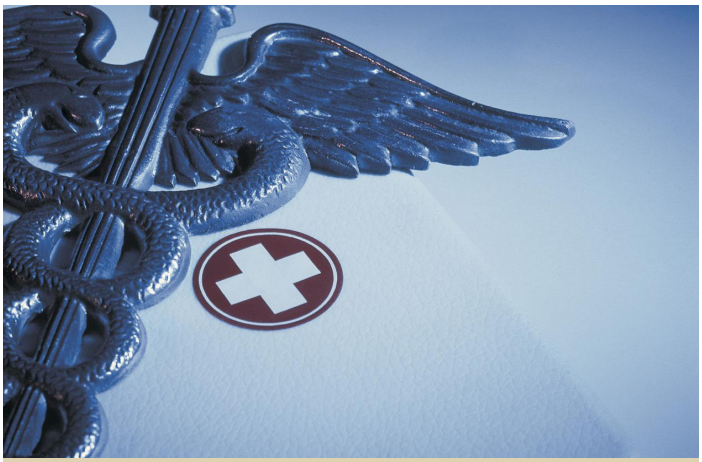

March 2017 • Volume 7, Number 1

IN THIS ISSUE

DW HEALTHCARE BLOG
http://www.dwhealthlawblog.com/

DICKINSON WRIGHT'S

HEALTHCARE **LEGAL**NEWS

HEALTHCARE TAX AND LEGISLATIVE UPDATES

EXPANSION OF PRACTICE AUTONOMY OF PHYSICIAN ASSISTANTS

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As part of a flurry of activity at the end of 2016, Public Act 379 was enacted by the Michigan legislature and signed by Governor Snyder. That Act amends various provisions of the Michigan Public Health Code regarding the professional relationship of physician assistants ("PAs") with physicians and podiatrists and the professional independence of PAs. The Act's provisions take effect on March 22, 2017. Physician practices and other entities that employ PAs will need to address these changes by that date.

Professional Relationship between PAs and Physicians

Previously, Michigan law required PAs to work under the supervision and delegation of a physician or a podiatrist. The new Act deletes those terms from the Michigan Public Health Code. For example, while a PA still cannot practice except through a specified association with a physician or a podiatrist, the general intent behind these changes is to create a legal structure that fosters a more collaborative approach to patient care between PAs and physicians and that authorizes greater independence and autonomy for PAs treating patients within their general scope of practice. As part of that, the Act deletes an existing statutory provision prohibiting a physician from delegating ultimate responsibility for medical care services to a PA. Two practical effects of these changes are that a physician is no longer required to countersign a PA's orders as part of a patient's medical chart and that a PA may sign certain official forms without a physician's co-signature when the PA has treated the patient.

PAs as Independent Prescribers

Another significant change under this Act is that PAs are now included as independent prescribers for purposes of Michigan pharmacy regulations and can thus issue prescriptions under their own names and dispense complimentary starter doses without physician supervision or delegation. Formerly, a prescription written by a PA had to be authorized by a physician and issued under the name (and, if applicable, the DEA number) of both the PA and the physician. A PA can now also obtain his or her own Michigan controlled substance license in addition to a DEA license and prescribe permitted controlled substances in his or her own name. While application forms are already available for Michigan PA controlled substance licenses, they will not

be approved before March 22. Although the new changes do not place additional limits on drugs that PAs can prescribe, Michigan law still prohibits PAs from prescribing medical marijuana and abortive drugs.

Mandatory Practice Agreements

Instead of being subject to the supervision and delegation of a physician or a podiatrist, the Act mandates that a PA must now enter into a "practice agreement" with a participating physician or podiatrist. Without such a practice agreement, a PA may not practice in Michigan after March 22. Likewise, a physician group practice or other entity that employs PAs must have such an agreement in place by that date with each PA that it employs. A practice agreement does not have to be submitted to any agency, but it must be signed and dated by the PA and the participating physician or podiatrist and made available upon request by an appropriate governmental agency.

The practice agreement must be between a PA and an individual participating physician or podiatrist. A group practice can, however, designate one or more of its physicians or podiatrists to enter into practice agreements with PAs. In other words, a PA does not have to have a separate practice agreement with each physician of a group practice; instead, one or more designated physicians of the practice may enter into such agreements with the PAs employed by a practice to satisfy this requirement.

The main purpose of the practice agreement is to identify the respective duties and responsibilities of the PA and the participating physician or podiatrist. The practice agreement cannot include any duty of a PA that he or she is not qualified to perform by education, training, or experience or that is not within the scope of the PA's license. The practice agreement can, however, include additional limitations on a PA's scope of practice as part of his or her employment with a group practice. For example, even though a PA is legally authorized to prescribe independently, a physician practice can still impose additional limits on a PA's ability to prescribe for the group's patients as part of a practice agreement.

The practice agreement must specify a process between the PA and the participating physician or podiatrist for communication, availability, and decision-making for providing medical treatment to patients that takes into account the knowledge and skills of the PA based on his or her education, training, and expertise. The practice agreement must also contain a protocol for designating an alternative physician for consultations in situations when the participating physician is not available. As part of the practice agreement, the participating physician must verify the PA's credentials. The practice agreement must also require notice of at least 30 days by either party before termination.

Nothing in the Act prohibits an employment agreement with a PA or an addendum to an employment agreement from containing the provisions required for a practice agreement. Depending on the associated details and the approach of a practice, a separate practice agreement may make sense in many situations especially because of the requirement that a practice agreement can be terminated only with at least 30 days' notice.

Under the provisions of the Act, the failure to practice in accordance with the terms of a practice agreement can be the basis for disciplinary action under the Public Health Code against a PA, a physician, or a podiatrist. In addition, an applicable licensing board may prohibit a PA, a physician, or a podiatrist from entering into a practice agreement due to violations of the Public Health Code.

Physician/PA Ratio and Licensing Board Authority

Under current regulations, a physician can supervise a maximum of four PAs (only two if the oversight involves more than one practice site without in-person supervision). The Act eliminates that restriction and replaces it with a directive to the Michigan Board of Medicine, in consultation with the Michigan Board of Osteopathic Medicine and Surgery and the Michigan Board of Podiatric Medicine and Surgery, to consider whether to impose a new maximum ratio of PAs to participating physicians or podiatrists as part of a practice agreement. Until new regulations are developed, the Act generally limits a participating physician or podiatrist to a reasonable standard of practice with respect to the number of PAs under his or her oversight. The Act also authorizes those boards to prohibit PAs from providing certain medical services and to restrict certain medical services only to physicians or podiatrists if those services require extensive medical training, education, or ability or pose serious risks to the health or safety of patients.

Liability

Under existing law, a physician or podiatrist must supervise a physician assistant's medical services and the services provided by the PA must be delegated by the supervising physician. This results in nearly automatic liability of a physician (and a physician practice) for the actions of a supervised PA.

While the new Act does not explicitly address the liability of a physician or a podiatrist for the services of a PA, it does establish a more independent scope of practice for PAs. As a result, physicians and podiatrists should not have the same broad automatic liability for the actions of a PA (although, as the employer of record, a physician practice remains legally liable for the actions of its employees, including PAs). It seems likely, however, that efforts will be made to use the existence of a practice agreement and the associated relationship between a PA and a participating physician or podiatrist to try to establish liability of a participating physician or podiatrist for the actions of a PA. In addition, a physician who consults with a PA regarding a particular patient matter faces potential liability for any resulting bad outcome just as when a physician consults with another physician. This is sure to be the subject of future litigation and court rulings.

Professional Liability Insurance

Some professional liability carriers already issue separate policies for PAs. With some carriers, PAs are covered for malpractice claims by being named as additional insured parties to a physician's professional liability policy. The changes under the Act that expand the independence of PAs may result in the more widespread use of individual policies for PAs. Physician practices that employ PAs should review this issue with their malpractice carriers.

Billing and Reimbursement

Under existing billing practices, a physician assistant may bill Medicare under his or her own name for covered services provided to a Medicare patient. In that case, the services are reimbursed at a lower rate. (If the applicable incident-to rules are followed, a PA's services to a Medicare patient can instead be billed under the supervising physician's name and reimbursed at the physician's rate.) Commercial payors vary in their approach, with some reimbursing separately for services provided by PAs while others do not.

The Act is silent regarding billing and reimbursement matters and, as a state law, will not have any impact on Medicare reimbursement. As a result, the Act itself will not change billing or reimbursement for PAs. But the Act's expansion of the independent scope of PA practice may lead commercial payors conducting business in Michigan to reevaluate how they handle billing and reimbursement for services provided by PAs.

Rounding and House Calls

Currently, a PA may round on patients or make house calls only under the supervision of a physician. That restriction has been replaced, and a PA is now permitted to perform those services independently in accordance with a practice agreement.

Implications for Physician Group Practices

Physician group practices and other entities that employ PAs should begin addressing these matters soon to allow enough time to implement these new requirements before March 22.

IRS ISSUES NEW GUIDELINES FOR QUALIFIED MANAGEMENT CONTRACTS FOR FACILITIES FINANCED WITH TAX EXEMPT BONDS

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Health care providers with facilities financed with tax exempt bonds need to be aware of recent changes to the IRS rules for qualified management contracts. On August 22, 2016, the IRS issued Rev. Proc. 2016-44 which replaced the safe harbors for management contracts previously set forth in Rev. Proc. 97-13 with new safe harbors that are intended to provide more flexibility with respect to term and compensation arrangements. On January 17, 2017, in response to feedback received on the new rules, the IRS issued Rev. Proc. 2017-13, which supersedes Rev. Proc. 2016-44. The safe harbors under Rev. Proc. 2016-44 became effective for any contract entered into on or after August 22, 2016 and may be applied to any management contract entered into before August 22, 2016. The safe harbors under Rev. Proc. 2017-13 became effective for any contract entered into on or after January 17, 2017 and may be applied to any management contract entered into before that date. In addition, the prior safe harbors in Rev. Proc. 97-13 may continue to be applied to a management contract that is entered into before August 18, 2017 and that is not materially modified or extended on or after August 18, 2017 (other than pursuant to a permissible renewal option).

Background

Section 145 of the Internal Revenue Code permits nonprofit 501(c)(3) corporations to borrow money through the issuance by state or local units of government of tax exempt private activity bonds known as "qualified 501(c)(3) bonds." The proceeds of such qualified 501(c)(3) bonds are loaned by the bond issuer to the 501(c)(3) borrower to finance capital expenditures for facilities that will be used in furtherance of the charitable purposes of such institution. Nonprofit hospitals, assisted living facilities, nursing facilities, senior retirement communities, universities and other nonprofit institutions frequently use this type of tax exempt bond financing for large capital projects.

The Internal Revenue Code restricts the amount of "private business use" which may occur at facilities financed with tax exempt qualified 501(c)(3) bonds. Failure to comply with these restrictions may cause the bonds to lose their exemption from federal income taxes and may require the 501(c)(3) borrower to undertake certain remedial actions. Private business use may occur as a result of a management contract or service contract with a party that is not a governmental entity or a 501(c)(3) corporation. A management contract with respect to financed property generally results in private business use of that property if the contract provides for compensation for services rendered based in whole or in part on the net profits from the operation of the managed property. The IRS rules for qualified management contracts are intended to provide guidance as to how to structure management contracts to avoid private business use.

More Flexible Approach to Compensation Arrangements

The previous safe harbors under Rev. Proc. 97-13 were formula driven based on the nature of the compensation and duration of the contract. Under the new rules of Rev. Proc. 2017-13, the IRS has adopted ostensibly a more flexible approach by permitting any type of fixed or variable compensation so long as it is "reasonable compensation" for the services rendered under the contract. However, the compensation may not be based on net profits from operating the facility and cannot be contingent on the managed facility's net profits or both revenues and expenses of the managed facility (other than any reimbursements of direct and actual expenses paid by the service provider to unrelated third parties).

Incentive Compensation

Incentive compensation is not treated as based on a share of the net profits if the eligibility for the incentive compensation is determined by the service provider's performance in meeting one or more standards that measure quality of services, performance, or productivity, and the amount and timing of the payments meets the requirements described below.

Treatment of Certain Types of Compensation

Rev. Proc. 2017-13 clarifies that compensation arrangements which are based on the familiar fee arrangements identified in Rev. Proc. 97-13 can continue to be eligible fee structures. Thus, a capitation fee, periodic fixed fee, or a per-unit fee, or any combination thereof, as well as certain types of incentive compensation as described above, are all eligible.

Treatment of Timing of Payment of Compensation

A deferral of compensation due to insufficient cash flows from the operation of the managed property will not cause the deferred compensation to be contingent upon net profits or net losses if the contract includes requirements that:

1. the compensation is payable at least annually;

2. the qualified user is subject to reasonable consequences for late payment, such as reasonable interest charges or late payment fees; and

3. the qualified user is required to pay all deferred compensation (with interest or late payment fees) no later than the end of five years after the original due date of the payment.

No Bearing of Net Losses

The contract must not impose upon the service provider the burden of bearing any share of net losses from the operation of the managed property. An arrangement is not treated as bearing a share of net losses if: (i) the determination of the amount of the compensation and amount of any expenses to be paid by the service provider (and not reimbursed) do not take into account either the managed property's net losses or both the managed property's revenues and expenses for any fiscal period; and (ii) the timing of the payment of compensation is not contingent upon the managed property's net losses.

Term of the Contract and Revisions

A significant change by Rev. Proc. 2017-13 is the permissible term of the contract. Under Rev. Proc. 2017-13, the term of the contract, including all renewal options, may not be greater than the lesser of 30 years or 80% of the weighted average reasonably expected economic life of the managed property. Rev. Proc. 2017-13 provides that land will be treated as having an economic life of 30 years if 25% or more of the bonds that financed the managed property financed land. Under Rev. Proc. 2016-44, land was never taken into account, which could have reduced the permitted maximum term of the contract. While Rev. Proc. 2017-13 sanctions the use of longer term arrangements, it requires that all long-term -- or even short-term -- contracts meet the safe harbor. 501(c)(3) borrowers must now more closely scrutinize the remaining useful life of the "managed assets" at the time of entering or materially modifying a contract to assess whether the contract's term is permissible under the safe harbor.

Control Over Use of Managed Property

The qualified user (the 501(c)(3) borrower) must exercise a significant degree of control over the use of the managed property. This control requirement is met if the contract requires the qualified user to approve the annual budget of the managed property, capital expenditures with respect to the managed property, any disposition of the managed property, rates charged for use of the managed property, and the general nature and type of use of the managed property. Rev. Proc. 2017-13 loosened the approval process by permitting a qualified user to show (i) approval of capital expenditures by approving an annual budget for capital expenditures described by functional purpose and specific maximum amounts, and (ii) approval of rates by approving a general description of the methodology for setting such rates or by requiring that service provider charge rates that are reasonable and customary as specifically determined by, or negotiated with, an independent third party (such as a medical insurance company).

Risk of Loss

The qualified user must bear the risk of loss upon damage or destruction of the managed property.

No Inconsistent Tax Position

The service provider must agree not to take any position that is inconsistent with being a service provider to a qualified user with respect to the managed property. For example, the service provider must agree not to claim any depreciation or amortization deduction, investment tax credit, or deduction for any payment as rent with respect to the managed property. In other words, the 501(c)(3) borrower must remain the tax owner of the bond-financed property.

No Substantial Limitation of Rights

The service provider must not have any role or relationship with the qualified user that in effect substantially limits the qualified user's ability to exercise its rights under the contract. A service provider will not be treated as having a prohibited role or relationship if:

1. In the aggregate, no more than 20% of the voting power of the governing body of the qualified user is vested in directors, officers, shareholders, partners, members and employees of the service provider or any of its related parties;

2. The governing body of the qualified user does not include the chief executive officer of the service provider or the chairperson of its governing body; and

3. The chief executive officer of the service provider is not the chief executive officer of the qualified user or any of the qualified user's related parties.

Nonprofit 501(c)(3) health care providers with tax exempt financed facilities will need to consider these management contract guidelines when negotiating service contracts with third parties who will use such facilities.

SO YOU WANT TO 'MAKE PARTNER': A WORD OF WARNING TO JUNIOR PROFESSIONALS, WATCH WHAT YOU WISH FOR

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Group medical and dental practices often look to expand their practices by hiring additional professionals, typically those with less experience than the equity owners of the practice group. Invariably, both the group practice and the potential new hire will insist on an employment agreement that will provide the practice group with protection that the junior professional will continue to provide services to the group during a specified time period and that will assure the professional of payment for providing services. In addition, the potential new hire will request that the employment agreement provide for the opportunity to "make partner" within a specified time period after the date of hire. This initial time period before the newly employed professional is considered for equity participation is typically viewed as a probationary period during which the parties will see if the relationship is a "good fit". The group practice will accede to the junior professional's request for equity participation after a limited time period of employment in order to "align the incentives" of the professional with that of the practice and also to facilitate in business succession of the practice group such that the group (or the junior professional) can pay the more senior equity owners for their equity interests in the practice as they retire. So far, so good?

By focusing on the business aspects of the employment relationship and possible equity participation, the tax aspects of the arrangement may be overlooked by the practice group and are generally ignored by the professional who is being hired. For example, the practice group owners and the junior professional are generally aware of the various "payroll taxes" (Medicare, Social Security and state and federal unemployment taxes) that apply during the initial phase of the employment agreement during which the professional is an employee but not an equity owner. During this time period, regardless of the structure of the practice for federal tax purposes (i.e., PC vs PLLC), the group practice as employer pays the "employer side" of payroll taxes and the employee pays the "employee side" of payroll taxes via tax withholdings. For example, the group practice and the employed professional will each pay old age, survivors and disability insurance (OASDI, or Social Security) taxes of 6.2% of compensation paid to the junior professional up to an annually specified cap ($127,200 for 2017). In addition, the group practice and the employed professional will each pay hospital insurance (Medicare) taxes of 1.45% of compensation paid to the junior professional (not capped).

However, depending on how the group practice is organized for federal tax purposes, the parties may overlook the federal tax consequences when the employed professional "makes partner" of the group practice, particularly as to payroll taxes for practices organized as a professional limited liability company (PLLC) or a professional limited liability partnership (PLLP). Specifically, subject to an exception for certain income of limited partners that will be discussed below, for professionals who perform services for PLLC's or PLLP's in which they are also equity owners, all compensation received by the professionals from the group practice will be subject to self-employment tax. For a junior professional being paid $100,000 in annual compensation before becoming an equity owner, the junior professional will pay through federal income tax withholdings Social Security taxes of $6,200.00 and Medicare taxes of $1,450.00, for a total of $7650.00 (7.65% of compensation). The group practice will pay the same amount for the "employer side" of these taxes. Once the junior professional "makes partner" of an unincorporated group practice (i.e., one taxed as a partnership for federal tax purposes), the professional will pay 15.3% in Social Security and Medicare taxes on income up to the annual Social Security income cap and 2.9% in Medicare taxes only on income above that annual limit. For the junior professional being paid $100,000, the Social Security and Medicare taxes for which the professional is responsible will increase from $7650 to $15,300, double what the employed professional paid before becoming an equity owner.

This often overlooked tax consequence to "making partner" was addressed in recent guidance issued by the Office of Chief Counsel ("OCC") of the Internal Revenue Service. In Chief Counsel Advice (CCA 201640014, issued 9/30/2016), the OCC found that all of a franchisee's share of earnings from a partnership that operates several restaurants is subject to self-employment taxes when the franchisee, an individual, served as the manager, President and CEO of the partnership. In reaching this conclusion, the OCC overruled the argument of the franchisee that the income derived from the partnership should be divided into two components, one that represented an investment return on contributed capital (exempt from self-employment tax) and another as compensation for services rendered by the individual to the partnership (subject to self-employment tax).

By asserting the argument that the franchisee's income from the partnership should be "split" into two streams (one subject to self-employment tax and another not subject to self-employment tax), the individual tried to distinguish the activities of the restaurant partnership from *Renkemeyer, Campbell & Weaver, LLP*, a 2011 Tax Court case in which the Tax Court determined that even though the attorneys who provided legal services for a law firm that was operated as a partnership were limited partners of the law firm partnership, their income from the partnership was subject to self-employment tax.

The CCA found that for the same reasons adopted in the *Renkemeyer* case, all of the individual franchisee's income from the restaurant partnership was subject to self-employment income and not just the guaranteed payments made by the partnership to the individual who was the principal owner of the partnership.

Despite the franchisee's delegation of a portion of the services required by the partnership to operate the franchised restaurants to an executive management team, the individual's entire distributive share of the partnership income should be treated as compensation for services rendered by the individual as president, chief executive officer and manager of the partnership. As a result, the income paid to the individual was not exempt from self-employment income tax under IRC §1402(a)(13) (exemption of limited partner's distributive share of income).

The main lesson to be learned from the CCA and from the *Renkemeyer* case is that before finalizing an employment agreement with a professional group practice that is organized as a PLLC or a PLLP, the professional should insist on an increase in compensation upon being admitted as an equity owner of the practice to compensate for the increase of self-employment and other payroll taxes. Otherwise, the professional's take home compensation may actually decrease as a result of "making partner". Hence, the title of this article …"Watch what you wish for…".

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DICKINSON WRIGHT'S BEHAVIORAL HEALTH CARE GROUP WRITES BOOK FOR AHLA

Dickinson Wright PLLC is pleased to announce that Attorneys Greg Moore, Russell Kolsrud, Peter Domas, Serene Zeni, and Alexandra Hall wrote and edited The *Fundamentals of Behavioral Health Care Law*, which is now available through the American Health Lawyers Association.

With more than 50 years of combined experience, Dickinson Wright's Behavioral Health Care lawyers continue to guide their clients through the complicated and exciting changes brought about by the Affordable Care Act. We have been and continue to be leaders in educating and counseling clients as parity and the integration of behavioral health and physical health take center stage.

Beginning in the mid-1950s, the approach to addressing serious behavioral health disorders began to shift from institutionalizing those afflicted to making community based outpatient treatment available. By 1970 community support programs began to appear with an emphasis on a fully continuous system of care that would serve the comprehensive needs of the seriously mentally ill. However, integrating behavioral and physical health requires that the applicable jurisprudence evolve at the same pace, and this faces resistance. Despite state legislatures' policy decisions that persons with mental illness can live in our society as functioning individuals, our jurisprudence of tort and injury law is often an impediment to that goal.

The *Fundamentals of Behavioral Health Care Law* is the go-to reference for health care institutions, social service providers, and the lawyers who represent them, will serve as an introduction to the complex questions posed by behavioral health and the law.

Topics include:

- Change from institutionalization to community based outpatient system of care
- Legal duty owed by behavioral health providers to others
- Hindsight bias and its effect on behavioral health jurisprudence
- Criteria for when someone can be subjected to involuntary psychiatric treatment
- The impact of patient's illness on the rules that govern treatment records
- Integration of behavioral health with physical medical issues
- Includes behavioral health terminology, acronyms, abbreviations, and a list of governmental entities involved in behavioral health
- State charts on civil commitment, duty to ward, and confidentiality of mental health records

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