HOSPITALS

New Revenue Procedure is Here to Stay

Out with the old and in with the new? A recent revenue procedure change is catching the attention of health care providers with facilities financed through tax-exempt bonds. The good news is, the changes allow for greater flexibility and revised safe harbor guidelines.

The Internal Revenue Code (IRC) provides that interest on bonds issued by governmental or 501(c)(3) organizations may be exempt from tax if, in addition to satisfying other requirements, not more than 10% of the proceeds of the debt issuance for governmental entities (5% for 501(c)(3) organizations) are utilized in a private business use (a private party such as a medical practice or for-profit service provider may qualify as a private business use). As a result, traditional service agreements between hospitals and medical practices and other arrangements to manage segments of hospitals' businesses may be considered management agreements and could cause financings to fail the private business use test. This would result in interest on bonds being taxable.

In order to prevent such a result, hospitals with outstanding tax-exempt debt historically sought to fit management and service agreements into one of a multitude of complex and often burdensome private use safe harbors under the Internal Revenue Service (IRS) Revenue Procedure 97-13 (Rev. Proc. 97-13). These safe harbors were tied to the length of the agreement and the type of compensation provided to the service provider. If a safe harbor was satisfied, then the agreement would not qualify as a private business use.

Because the safe harbors were extremely technical and complex, on August 22, 2016, the IRS issued Revenue Procedure 2016-44 (Rev. Proc. 2016-44) as a replacement to Rev. Proc. 97-13. Rev. Proc. 2016-44 has been lauded in the industry as providing greater flexibility for management and service agreements to qualify for private use safe harbors. Gone are the rigorous tests of the past that tie modes and forms of compensation to the length of agreements.

However, in the health care context, while the modes of compensation and lengths of agreements have been liberalized, there are a few provisions in Rev. Proc. 2016-44 that are likely to be viewed as more restrictive than Rev. Proc. 97-13 and may be viewed by clients as unnecessary or prohibitive in securing needed physician services. There are also numerous outstanding questions caused by the vagueness of the safe harbor as it relates to typical health care contracts.

New Safe Harbor Provisions

For a management or service agreement to fit within Rev. Proc. 2016-44, the following elements must be satisfied:

- **Reasonable Compensation**: The compensation paid to the service provider must be "reasonable" for the services rendered. Instead of analyzing whether the compensation methodology is a periodic fixed fee, per unit fee or percentage of revenue or expense fee, now, the compensation must only be reasonable.
- **No Net Profits or Losses**: As before, compensation cannot be tied to the net profits or net losses of the hospital or any service line or department of the hospital. Importantly, for purposes of many alternative payment methodologies and accountable care organization (ACO) activity, incentive compensation based on meeting quality, performance or productivity standards is not considered to be based on net profits. Likewise, compensation tied solely to revenue or expenses, but not both, may be permissible. However, provisions that delay or subordinate payment of fees to profitability or availability of funds can be viewed as a "net profits" arrangement.
- **Risk of Loss**: The service provider cannot bear the risk of loss due to damage or destruction of the hospital or managed property.
- **Term**: The term of the agreement may be no greater than the lesser of 30 years or 80% of the weighted average of the reasonably expected economic life of the property subject to the agreement. This is a significant lengthening of the typical safe harbor contract terms relied upon by hospitals under Rev. Proc. 97-13. However, as further described below, this provision can be a significant impediment if the property being financed is older or otherwise close to the end of its useful life, which may be the case in many refinancings.
- **Control of Property**: The hospital must control the financed property. This means that the hospital must retain authority over matters such as approval of budgets, capital

expenditures, disposition of property, rates charged for use of the property, and the general nature and type of use of the property.

- Inconsistent Tax Position: The service provider must formally agree that it will not take an inconsistent tax position with regard to the agreement and managed property, for example, by taking amortization or depreciation expense write-offs as if it owned the property.
- Relationship of Parties: The safe harbor requires that there be no circumstances (on a fact and circumstances basis) that would effectively prevent the hospital from exercising its rights under an agreement. Rev. Proc. 2016-44 states that safe harbors that provide an arrangement will not be viewed as violating this term so long as:
  - No more than 20% of the voting power of the hospital's board rests with directors, officers, shareholders, employees, etc. of the service provider;
  - The chief executive officer (CEO) or chairperson of the service provider does not sit on the hospital's board; and
  - The CEO of the service provider is not also the CEO of the hospital or any related parties of the hospital.

Potential Road Blocks

While Rev. Proc. 2016-44 does make some substantial improvements over Rev. Proc. 97-13, there remain a few significant outstanding questions.

To maintain control of the property, hospitals must approve of the rates charged for use of the property. Under Rev. Proc. 97-13 there was a well-known split of opinion over whether hospitals were required to actually approve of the fees charged by physicians to patients. However, within the confines of Rev. Proc. 97-13, that issue only mattered insomuch as the hospital needed to use a "per unit" fee safe harbor. Under Rev. Proc. 2016-44, to receive protection of the safe harbor, an agreement must provide that the hospital approves the rates charged by the service provider (physician). This applies to any service agreement needing safe harbor protection, regardless of whether the compensation is a periodic fixed fee, per unit fee, or no fee at all. In the past, many split-bill arrangements only gave hospitals the right to review and potentially object to the physician's fees, if any rights were given at all. Express approval by the hospital is now required.

Further, while the potential length of permissible management contracts has been significantly extended, a question remains over the usefulness of this safe harbor for new management or service agreements that are entered into later in the useful life of the financed property. For example, if a hospital has bond-financed assets that are well into their useful lives (say the facility is 35-years-old and has a useful life of 40 years) and the radiology group wants to enter into a five-year agreement, the arrangement would technically not satisfy the safe harbor since the limit would be 80% of the remaining useful life (four years).

Many hospitals include physician members on their boards. One instance where this could be a problem is when a physician who is the head of a practice group with which the hospital has a contract is elected to the hospital's board after the agreement is executed. Likewise, it could arise where the chief of staff has an ex officio position on the hospital board and the newly elected chief of staff has a leadership role with a contracted group. These circumstances do not in and of themselves eviscerate the Rev. Proc. 2016-44 safe harbor, but they remove the "substantially limiting the exercise of rights" safe harbor and move the analysis to a facts and circumstances test.

These outstanding questions affect health systems and their counsel as they work to contract with physicians and physician groups for needed services. They also impact due diligence and review standards for bond counsel and underwriters as hospitals seek to go to market. While Rev. Proc. 2016-44 does lessen the structure surrounding management safe harbors in some very important ways, it also may make contracting with physicians and physician groups more burdensome than before.

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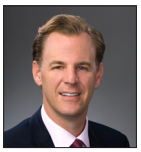

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