



HEALTH LAW DEVELOPMENTS

November 2001

Court of Appeals Reverses Family Court on Withdrawing Futile Life Support for Neonate	1
IRS Issues 2002 Exempt Organizations Textbook	5
Medicare Update	7
OIG Advisory Opinion Finds Hospital Joint Ventures Outside Safe Harbor but Permissible.	8
Michigan Attorney General Limits Rights of Non-Custodial Parents	9
View from the IRS National Office.	11
Michigan House Acts on Commission on End of Life Care Legislative Recommendations	12

COURT OF APPEALS REVERSES FAMILY COURT ON WITHDRAWING FUTILE LIFE SUPPORT FOR NEONATE

The Michigan Court of Appeals issued its opinion in *Family Independence Agency v. AMB* (Court of Appeals No. 218869) last week. Calling the case a heartbreaking “human tragedy” with “truly appalling” facts, the Court reversed Wayne Circuit Court Family Division, finding the proceedings “unredeemably flawed,” and in “relentless disregard for basic principles.” The primary focus of the case is on the failure of the Family Court (FC) to enforce the civil rights of AMB and her parents under state statutes and

constitutional law, and on the pressure exerted by the Family Independence Agency (FIA) for an order authorizing withdrawal of life support.

Effect of the Case on the Development of Michigan Law on Withdrawing Life Support

Fortunately, the AMB case does not materially change Michigan law on withdrawal of life support for minors. *In re Rosebush*, 195 Mich App 675 (1992), is still the seminal Michigan case on the subject. It underscores that the decision is principally that of the family or other appropriate surrogates (with advice of medical and spiritual advisors, according to *Rosebush*). Court intervention is neither favored nor required in the absence of disagreement among decision makers or between decision makers and the medical team, or other “appropriate reasons.” Here, the judicial process was improperly invoked when FIA took it upon itself to assume the mantle of responsibility not because of impasse, and “pressed for an order” to remove life support.

This case holds for the first time in Michigan that the clear and convincing evidence standard must be used to determine best interests using the factors set forth in *Rosebush*. The Michigan Supreme Court in *In re Martin*, 450 Mich 204 (1995), required clear and convincing evidence to exercise the substituted judgment test based on the prior expressed wishes of an incompetent, but conscious adult in no apparent pain, as to whether the adult would want life support withdrawn.

Secondly, the opinion requires the petitioner to have an independent corroborating medical opinion from a physician not involved in the treatment, or present sound reasons why it is not necessary. The *Rosebush* court cited out of state cases favoring second opinions, but did not impose an invariable requirement.

Another significant holding is that it is not necessary to decide whether withdrawing life support is a treatment decision. A court may exercise an incompetent person’s right to refuse treatment, as a corollary of the right to informed consent, or uphold a physician’s judgment that treatment is futile or harmful to the patient, when death is unavoidably imminent.

Facts and History of the Case

Baby AMB was born prematurely without a septum dividing the chambers of the heart, with deformed heart valves, a small aorta, a collapsed left lung, malformed hip joints, and an intestinal anomaly of some kind. She had hydrocephaly and other brain abnormalities, which were not life threatening. AMB’s maternal grandfather JB was alleged, but not legally determined, to be her father. Her mother KB was alleged to be mentally retarded, with some form of developmental delay, but there was never a formal adjudication of KB’s incompetence.

FIA filed a petition asking the court to take temporary custody of AMB. At the hearing, AMB’s court appointed attorney objected to any order granting FIA authority other than to consent to routine care, without a fully informed decision about AMB’s medical needs, and recommended a petition for a protective order for KB based on her alleged incompetence.

FIA amended its petition as to AMB on the basis of medical evidence that AMB was in physical distress and had no prospect for long-term survival independent of life support. AMB’s physician recommended removal of life support (as causing suffering without ameliorating AMB’s dire health problems), and recommended fluids, warmth and possibly a feeding tube for comfort because further care was futile and inhumane. AMB’s attorney had no notice of hearing on the amended petition. “Emergency house counsel” was selected just

before the hearing. It is unclear whether KB or JB had notice; neither appeared. There was testimony that KB had extremely limited understanding, but knew that AMB had “significant heart problems.”

The referee entered an order allowing the hospital to remove AMB from life support and medication, if comfort care were offered because “prolonging the child’s life would only prolong her suffering.” Seven days were allowed for appeal to an FC judge and 21 days to the Court of Appeals. Life support was withdrawn two days later, and AMB died.

Six days later, AMB’s appointed attorney filed an appeal. FC denied review because the case was moot, indicating that court personnel would review FC procedures to determine if there were a better way to handle future cases. The Court of Appeals dismissed an appeal on the basis that the attorneys had no authority to act on behalf of AMB. The Michigan Supreme Court reversed and remanded the case to the Court of Appeals, directing this proceeding.

Failure of Family Court (FC) to Obtain Jurisdiction and Respect Rights of the Parties

- Judicial intervention is warranted if “the parties directly concerned disagree about treatment, or other appropriate reasons” exist, such as parental incapacity. The minor may have a guardian ad litem, depending on the gravity of the medical decision and the time available, and is always entitled to an attorney who will advocate zealously for the minor. The attorney must observe and, when possible, interview the child; review the case file; and consult with/interview others having information (e.g., parents, guardians, foster parents, caseworkers, medical personnel). Substitution of attorneys is not favored. FC must ensure that a substitute is well prepared, and, if necessary, determine whether ineffective counsel led to an outcome that was not in the child’s best interests.
- FC has jurisdiction over children under age 18 whose parents are neglectful or fail to provide a fit home. FC could make decisions about AMB’s medical care, if it found in an adjudicatory hearing by clear and convincing evidence that her parents lacked capacity to make the critical medical decision at issue. Because of the lack of an adjudicatory hearing, FC failed to acquire jurisdiction over AMB under the Juvenile Code.
- Parties affected (e.g., parents or guardians) have a fundamental liberty interest and have statutory and constitutional due process rights to notice and an opportunity to be heard. FC was required to assure actual notice to KB despite her alleged incompetence. JB was in jail because of charges of incest, but moral judgments do not substitute for notice.
- If FC had jurisdiction, action could have been warranted in light of the hospital’s need for direction, KB’s lack of capacity and the lack of any other appropriate surrogate.
- A corroborating independent medical opinion is required in court cases involving withdrawal of life support. FC may weigh the presence or absence of medical consensus, the factors that contribute to medical agreement or disagreement and the factors that make an independent physician opinion more or less relevant to the ultimate decision.
- FC jurisdiction would not be limited to ordering medical treatment. FC could exercise the right to refuse medical care, as a corollary of the right to informed consent, or support a physician’s decision to make a patient comfortable when death is imminent.

- Under another part of the child welfare laws, FC could order routine nonsurgical medical care or emergency medical or surgical treatment, prior to adjudicating parental capacity, as long as it first respected the judicial policy disfavoring court intervention in a life support decision by making every effort to hold the adjudication hearing first.
- When FC referees conduct hearings on life support, they must make written findings and recommendations to a judge. Parties have seven days to request judicial review. In an emergency, they may agree to an immediate hearing or other steps to expedite the matter. A judge must make the decision in reality, not just form, and personally sign the order.

Effect of Other Federal and State Laws on Decisions to Withdraw Treatment

- Under the federal Child Abuse Prevention Treatment and Adoption Reform Act (CAPTA), it is not neglect to withhold treatment (other than nutrition, hydration or medication) that merely prolongs dying, would not ameliorate or correct all of the infant's life threatening conditions, is futile in terms of survival or virtually futile and inhumane.
- The federal Emergency Medical Treatment and Active Labor Act (EMTALA) does not require indefinite ventilator support when, after extensive efforts, the patient cannot be stabilized. EMTALA does not abrogate the common law right to informed consent or the corollary right to refuse treatment.
- Claims under the federal Americans with Disabilities Act (ADA) and the Michigan Persons with Disabilities Civil Rights Act (PWDCRA) must first be raised in the lower court. ADA claims could be based on whether the physicians and FIA too quickly rushed to a decision by presuming KB's incompetence or prematurely assessing the degree of AMB's disabilities.

Substantive Requirements for Withdrawal of Life Support for Infants and Children

- The first issue to be considered is whether a minor is of an age and maturity to make her own decision and exercise her own right to refuse treatment.
- Under *In re Rosebush, supra*, surrogates for an incompetent minor may make serious medical decisions, using the substituted judgment or best interest criteria, as relevant, based on clear and convincing evidence under either test.
- If an incompetent child were once competent, and there is clear and convincing evidence that she expressed an intent to refuse the treatment at issue when competent, the minor's choice may be enforced under the substituted judgment decisional standard. A limited objective standard may be used if there is some trustworthy evidence that the patient would have refused the treatment, and the decision maker is satisfied that it is clear that the burdens of continued treatment outweigh the benefits of that life - for that patient.
- If the child were never competent, or did not express her wishes when competent, the standard is what is in the child's best interest based on clear and convincing evidence, using the factors in *Rosebush* (current physical, sensory, emotional and cognitive functioning; pain from the condition, or treatment, or its termination; humiliation, dependence and loss of dignity; life expectancy and prognosis with and without treatment; and risks, benefits and consequences of treatment options and no treatment).

Practical Considerations for Health Care Providers, Bioethicists and Ethics Committees

The opinion raises a number of issues that should be considered for inclusion in health facility policies:

1. Should the clear and convincing evidence standard be used and documented in deciding what is in the best interests of a patient even when litigation is not anticipated?
2. Should a corroborating medical opinion be required when litigation is not anticipated? If so, how should it be determined that it is truly independent?
4. How can the risk of potential claims under the ADA or PWDCRA be minimized?
5. Must the facility monitor compliance with applicable laws by courts, guardians or agencies, such as FIA?
6. How can an institution verify the exact terms of a court order when it is not a party?

For further information about this case or assistance with policies, contact J. Kay Felt at (313) 568-6800 or kfelt@dykema.com.

IRS ISSUES 2002 EXEMPT ORGANIZATIONS TEXTBOOK

Articles by IRS personnel in the annual continuing professional education (“CPE”) textbooks have often been used to publicize IRS positions on issues affecting tax-exempt organizations, as well as to provide technical education for IRS employees. While the CPE Textbook for Fiscal 2002 released on October 3 does not contain very much information that can be called truly new, it does discuss a number of specific health care topics. It also contains general materials, especially with respect to the preparation of Form 990 information returns, the taxation of fringe benefits and participation in political campaigns, that may serve as useful references for tax-exempt health care organizations.

The health care subjects discussed in the 2002 CPE textbook include the following:

Joint Ventures

The participation by tax-exempt charitable organizations in joint ventures with for-profit entities to operate health facilities has been the subject of several recently decided and pending court cases and a formal IRS revenue ruling, Rev. Rul. 98-15, 1998-1 CB 718. These cases and the rulings have involved “whole hospital joint ventures” and ventures owning ambulatory surgery facilities in which the nonprofit organization has sought exemption based upon the health care activities of the joint venture and has had no other substantial charitable activities. The 2002 CPE Textbook generally adheres to the rather strict guidelines in Revenue Ruling 98-15 requiring that the joint venture function in furtherance of the charitable purposes of the exempt participant and under its control. The 2002 CPE Textbook does, however, say that in proper circumstances, the taxable participant may manage the venture. It also indicates that the IRS has approved exemption in cases in which the interest of the exempt participant in the venture has been as low as 50% (but not in any situations in which the interest was less than 50%). Because these cases and rulings have focused on organizations that do not have other significant health care programs, the IRS standards applicable to joint ventures involving organizations that do operate other health facilities continue to be unclear.

Hospital Indigent Care

Since 1969, the IRS has required hospitals seeking recognition of tax-exempt status under Section 501(c)(3) of the Internal Revenue Code to furnish emergency care without regard to ability pay, to treat individuals covered under governmental and private payments programs without discrimination and to follow certain rules with respect to its board and medical staff. The IRS recently released an internal “field service advice” that seemed to suggest that tax-exempt hospitals might have additional obligations to provide indigent care. (Since EMTALA now dictates that all hospitals that offer emergency services screen and stabilize all individuals who seek emergency services, there is reason to suspect that IRS personnel may be of the opinion that additional indigent care should be required of tax-exempt hospitals.) The 2002 CPE Textbook appears to reaffirm the 1969 rules, however, indicating that other charity care is necessary only when a hospital has no emergency room. Nevertheless, it should be noted that the 2002 CPE Textbook also reflects the long-standing IRS position that Medicaid recipients are classified as paying patients who must be served by tax-exempt hospitals without discrimination.

Other Health Care Issues

The 2002 CPE Textbook also: (a) contains a detailed discussion of the exemption from FICA taxes available for medical residents employed by a “school, college or university” and the IRS procedures for processing claims for refunds of such taxes; (b) discusses court cases which have had the effect of making it very difficult for most HMOs to obtain (or to retain) tax-exempt status under Section 501(c)(3) of the Code; (c) describes the requirements for exemption applicable to fitness centers affiliated with hospitals; and (d) indicates that “behavioral health consortia” created by unrelated community mental health organizations to negotiate and administer managed care contracts will be treated as being engaged in commercial business activities and will not be recognized as exempt. Also, despite the fact that the HHS Office of the Inspector General has issued an opinion permitting some “gainsharing” arrangements under which physicians participating in hospital cost reduction programs receive a portion of the resulting savings, the 2002 CPE Textbook indicates that it is unlikely that the IRS will issue rulings to tax-exempt hospitals approving such programs until it adopts regulations on revenue sharing arrangements for purposes of the excess benefits tax under Section 4958 of the Internal Revenue Code. Since the temporary regulations on excess benefit transactions currently in effect do not cover that subject, this suggests that it may be some time before any IRS guidance becomes available.

Other subjects addressed in the 2002 CPE Textbook that may prove useful to tax-exempt health care organizations include the following:

Form 990 Information Returns

One article in the 2002 CPE Textbook discusses filing and disclosure requirements applicable to the Form 990 exempt organization information returns. This article also contains rather detailed discussions of technical accounting issues and requirements for reporting executive compensation which may make it a useful reference for those preparing and reviewing returns.

Excess Benefit Tax and Employee Fringe Benefits

Another article in the 2002 CPE Textbook discusses the excise taxes on the payment of excessive compensation and other “excess benefit transactions” by Section 501(c)(3) and 501(c)(4) exempt organizations imposed under Section 4958 of the Internal Revenue Code. While the article follows the temporary regulations previously issued by the IRS rather closely, it also contains a lengthy discussion of the tax treatment of employee fringe benefits, such as employer-provided automobiles, moving expenses, business

entertainment, spousal travel, parking allowances, meals and tuition programs. As a result, this material may be as useful in addressing routine questions about tax reporting as it is in analyzing excess benefit tax issues.

Participation in Political Campaigns

Organizations exempt from tax under Sections 501(c)(3) and 501(c)(4) of the Internal Revenue Code are prohibited from participating in campaigns for public office. The 2002 CPE Textbook contains lengthy articles describing the kinds of actions the IRS will and will not consider to be in violation of this prohibition. These articles reaffirm that tax-exempt hospitals are prohibited from establishing or making contributions to political action committees, but suggest that they may establish and pay dues to a trade association having a PAC as long as funds given to the organization are not earmarked for political purposes.

Additional information is available from Jane Forbes at (313) 568-6792 or jforbes@dykema.com

MEDICARE UPDATE

Diagnostic Tests

The *Medicare Carriers Manual* was amended in late September to clarify a number of requirements relating to diagnostic tests.

Who May Order a Test. Diagnostic tests must be ordered by the beneficiary's "treating physician" or "treating practitioner" in order to be covered by Medicare. A "treating physician" is one who "furnishes a consultation or treats a beneficiary for a specific medical problem, and who uses the results of a diagnostic test in the management of the beneficiary's specific medical problem." For example, a diagnostic testing facility's medical director may not order a test unless he or she is treating the patient. The definition of "treating practitioner" is similar, but covers a nurse practitioner, clinical nurse specialist and physician's assistant. The requirement that a test be ordered by a treating physician/practitioner does not apply, however, to testing performed on a registered hospital inpatient or outpatient.

What Constitutes an "Order." The *Manual* now also defines the type of order required for a test to be covered by Medicare. An order may be:

- (a) in writing and signed by the treating physician/practitioner, and delivered in person, by mail or by fax;
- (b) via phone call by the treating physician/practitioner or "his/her office," and documented by both the ordering individual and the testing facility in their respective medical records for the patient; or
- (c) via e-mail, subject to the same terms as a phone order.

Modification of Original Order. The ordering physician/practitioner may, as part of his/her initial order, conditionally request a second test, e.g. "If test X is negative, then perform test Y." However, the testing facility may not change the original order or perform an additional test without a new order. The *Manual* permits a testing facility to perform an additional radiology test if the ordering physician/practitioner is not available and a number of specific requirements set out in the *Manual* are satisfied. The *Manual* also provides fairly detailed standards governing the ability of a pathologist or radiologist practicing outside a hospital to modify or determine what diagnostic services will be furnished when the treating physician/practitioner's order is incomplete or inappropriate.

Please contact Maria Abrahamsen to discuss these or related reimbursement issues, (248) 203-0818 or mabrahamsen@dykema.com.

PPS Transfer Versus Discharge

Enforcement. CMS (formerly HCFA) and the OIG announced this fall their intent to launch a joint initiative to recover from hospital overpayments made in inpatient PPS cases that were coded by the hospital as discharges but were in fact transfers. (A discharges triggers a full DRG payment, while transfer is paid on a per diem basis that often generates a total payment less than the DRG.) The cases in question are hospital discharges beginning January 1992. A number of Michigan hospitals are already negotiating with the U. S. Attorney's Office regarding potential federal False Claims Act cases related to the discharge/transfer issue.

Coding. Hospitals should be aware that beginning January 1, 2002 two new patient status codes will be used on the UB-92 billing form. The codes will designate a transfer to a rehabilitation hospital and a transfer to a long-term care hospital.

Please contact Seth Lloyd for information regarding discharge/transfer enforcement actions at (313) 568-6837 or slloyd@dykema.com, or Maria Abrahamsen for coding/reimbursement aspects of this issue.

OIG ADVISORY OPINION FINDS HOSPITAL JOINT VENTURES OUTSIDE SAFE HARBOR BUT PERMISSIBLE

On October 10, 2001, the Office of Inspector General of the Department of Health and Human Services ("OIG") issued an Advisory Opinion (No. 01-17) addressing an ambulatory surgery center joint venture. The OIG concluded that, based on the analysis summarized below, it would not impose sanctions in connection with the joint venture despite the fact that the various elements of the joint venture did not meet all of the requirements of the applicable safe harbors.

Facts

The ambulatory surgery center ("ASC") was a freestanding facility owned by a hospital affiliate (25%) and five individual ophthalmologists (75%), representing two separate practices. The ophthalmologists owned their interests in the ASC indirectly through limited liability companies. The return on the investment in the ASC by the hospital and the ophthalmologists was directly proportionate to their respective investments. The joint venture, in making its request for the Advisory Opinion, certified to the OIG that the joint venture complied with the "one-third practice income test" set forth in the ambulatory surgery center safe harbor (42 CFR §1001.952(r)(2)(ii)). The joint venture also certified to the OIG that it met all of the requirements of the ambulatory surgery safe harbor, except that the hospital was in a position to make referrals and the physician interests were indirectly owned (42 CFR §1001.952(r)(4)).

Because the hospital was in a position to make referrals, the hospital agreed that it would do the following: (i) physicians employed by the hospital would not make referrals directly to the ASC, but could refer to ophthalmologists, including the investors; (ii) the hospital would not take any actions to require or encourage hospital-affiliated physicians to refer to the ASC; (iii) the hospital will not track referrals by hospital-affiliated physicians to the ASC; and (iv) the compensation paid to hospital-affiliated physicians, whether employees

or independent contractors, would not be related in any way to the volume or value of referrals by such physicians to the ASC.

The joint venture further agreed that the ASC, the investing ophthalmologists and their group practices would inform patients in writing and by posted notice of their ownership interest in the ASC and would not discriminate against Medicare beneficiaries.

In addition to the ownership interests, the ASC leased space from the hospital and shared a common area with hospital outpatients, pursuant to a lease agreement between the hospital and the ASC and a partial leaseback agreement for a share of the reception area. The joint venture certified to the OIG that the lease and partial leaseback agreements met the requirements of the space rental safe harbor (42 CFR§1001.952(b)) The ASC also entered into a medical director agreement with one of the investing ophthalmologists. The joint venture certified that the medical director arrangement met the personal services contract safe harbor (42 CFR§1001.952(d)) except that the contract was for sporadic or part-time services and did not specify the exact schedule, time and intervals of service, and the aggregate compensation was not set in advance. The joint venture also certified that the payment made to the medical director was fair market value.

OIG Analysis

In reviewing the facts presented by the joint venture, the OIG analyzed the investment interests separate from the leases and medical director agreement. With respect to the investment by the hospital, the OIG acknowledged that the arrangement did not comply with the safe harbor, but concluded that the safeguards agreed to by the hospital (described above) “significantly constrai[n]” the ability of the hospital to induce or influence referrals. In addition, the OIG concluded that the fact the ophthalmologists’ interest in the ASC was indirect did not increase the risk of fraud and abuse.

The OIG also acknowledged that the leases and the medical director agreement did not comply with the applicable safe harbor, but concluded that the leases and the medical director agreement did not significantly increase the risk of fraud and abuse. The OIG specifically noted that the risk in the medical director agreement was reduced because the compensation was certified to be fair market value, it was based on a specified hourly rate, was subject to a cap, and was paid only if the hours and services provided were documented.

The OIG determined that the ASC joint venture did pose some risk of potentially violating the anti-kickback statute but that the OIG would not impose sanctions. The OIG took this position, in large part because of the safeguards put in place by the hospital, but also because it recognized that hospitals cannot compete with physician owned ambulatory surgery centers.

Contact Kathrin Kudner at (313) 568-6896 or kkudner@dykema.com regarding the legal issues associated with physician and hospital investment in ASCs and other health facilities/services.

MICHIGAN ATTORNEY GENERAL LIMITS RIGHTS OF NON-CUSTODIAL PARENTS

On October 16, 2001, Michigan Attorney General Jennifer Granholm issued Opinion No. 7092 construing the rights of non-custodial parents to obtain the treatment records of their children held by

licensed mental health services facilities, units, partial hospitalization programs and county community mental health boards or authorities and their contractors.

The Opinion centers upon conflicting language in the Michigan Mental Health Code Section 748 (dealing with confidentiality of mental health treatment records) and Section 10 of the Child Custody Act (dealing with non-custodial parents' general right of access to all information regarding their children, including medical information). The Mental Health Code requires the consent of the custodial parent for any disclosure of the child's mental health treatment records that is not otherwise required or permitted by the Mental Health Code. The question answered by the Opinion is whether (a) the restrictive "parent with legal custody" language of the Mental Health Code or (b) the broad grant of rights to non-custodial parents governs when a non-custodial parent seeks access to the child's mental health treatment records.

The Opinion concludes that the restrictive language of the Mental Health Code governs. A non-custodial parent may only obtain a copy of the child's mental health treatment records if the parent having legal custody of the child consents, and if the treatment provider does not opt to withhold information on the grounds the disclosure may cause substantial detriment. The only exception is the non-custodial parent's remaining right under the Mental Health Code to obtain a court order mandating disclosure to him or her.

At first glance this Opinion appears to upset the sometimes delicate political balance between divorced parents that is often crafted in the judgment of divorce. The Opinion appears to grant the custodial parent broad rights to withhold potentially valuable information from the non-custodial parent. However, the Opinion is more circumscribed than it would first appear. Today, there are many fewer parents who are deprived of "legal custody" than was the case in the past. "Legal custody" means in divorce law the ability to remain legally involved in significant decisions affecting the child. It differs from "physical custody," which is defined as the right to have the child live with the parent on a daily basis. Today, courts can and frequently do fashion custodial arrangements in which both parents share legal custody even if physical custody is granted exclusively to one parent. Similarly, courts grant joint custody arrangements in which the parents share both legal and physical custody. Accordingly, the practical impact of the Attorney General's Opinion will be to limit access to a fairly small group of parents who may in fact have little legitimate or beneficial use for the mental health information sought.

As with all issues of disclosure of health information today, it is germane to consider how the rule articulated by the Michigan Attorney General may fare once the privacy regulations of HIPAA become enforceable on April 14, 2003. As a general rule, HIPAA preempts all contrary state law, unless the state law is "more stringent than" HIPAA's provisions. Due to the complexity of HIPAA's handling of the access rights of parents of unemancipated minor children, the question of whether HIPAA will preempt this Attorney General Opinion may turn upon whether the individual divorce decree or other state law reserves to the non-custodial parent the right to consent to mental health services for the child. The Department of Health and Human Services has stated that it will issue guidelines concerning a parent's access to an unemancipated child's medical records prior to the HIPAA compliance date of April 14, 2003. Although distinctions between custodial and non-custodial parents have not to date been the focus of public comment about HIPAA's treatment of a parent's access to an unemancipated child's medical records, the issue may surface as DHHS delves into the

many nuances of the relationship between parent and child. Future issues of this newsletter will report major DHHS refinements or changes to the HIPAA privacy rules.

For more information on this Michigan Attorney General Opinion, HIPAA's privacy rules or other issues affecting medical or clinical records, please contact Joanne R. Lax at (248) 203-0816 or jlax@dykema.com.

VIEW FROM THE IRS NATIONAL OFFICE

Marvin Friedlander, Esq. of the Internal Revenue Service was the featured speaker at recent seminar sponsored by the American Health Lawyers Association. Mr. Friedlander has worked for the national office of the IRS in excess of 30 years. He currently manages the technical group that is responsible for issues pertinent to tax-exempt organizations. His seminar presentation addressed several issues of interest to tax-exempt health care organizations.

Joint Ventures

Mr. Friedlander spoke briefly about joint ventures between tax-exempt hospitals and for-profit entities. He reminded the seminar's attendees that Revenue Ruling 98-15 analyzes two arrangements involving whole-hospital joint ventures. This Revenue Ruling makes clear that a whole-hospital joint venture is likely to be approved when the arrangement serves the charitable purposes of the exempt hospital and the governing board of the exempt hospital has the authority to control the activities of the joint venture. Mr. Friedlander conceded, however, that the IRS is struggling with how to treat innovative ancillary joint ventures that do not fall neatly within the arrangements described in the Revenue Ruling. He said that his group will try to publish additional guidance on these arrangements, perhaps in the form of a voluntary compliance initiative.

Intermediate Sanctions

Mr. Friedlander reported that he has received numerous requests for rulings on situations involving excess benefit transactions and intermediate sanctions under Internal Revenue Code Section 4958. He said that the IRS will not rule on factual issues, such as whether a proposed transaction provides a disqualified person with an excess benefit. The IRS will rule, however, on issues concerning the elements of an excess benefit transaction, such as whether a particular individual is a disqualified person or whether any exceptions or safe harbors apply to the transaction.

Mr. Friedlander did not comment on when we can expect the temporary regulations on Section 4958 to be finalized, but he said that the IRS will publish additional guidance concerning excess benefit transactions and intermediate sanctions in the near future. His group is currently drafting new Internal Revenue Manual materials that will explain the "nuts and bolts" of computing the tax on excess benefit. They will also publish private letter rulings in response to twelve technical advice requests. These letter rulings will address the following topics:

- Determining the reasonableness of compensation paid pursuant to a "material modification" of a disqualified person's contract;

- Applying the “initial contract exception” to nondiscretionary payments paid before an individual became a disqualified person;
- Applying the “rebuttable presumption of reasonableness” to a potential excess benefit transaction;
- Measuring the reasonableness of deferred compensation paid to a disqualified person; and
- Determining whether the first and second-tier taxes should be abated after the disqualified person has corrected the excess benefit transaction.

Group Exemption

Mr. Friedlander noted that the IRS will issue a group exemption letter to the parent organization of an exempt hospital. Once a group exemption letter is issued, the parent organization will be able to update it annually with any additions or deletions to the group. The parent organization also will be able to file a single consolidated Form 990 on behalf of the exempt group.

Expanded Services and Alternative Medicine

Mr. Friedlander continues to receive applications and requests from hospitals seeking to offer expanded services, such as primary care services, fitness clinics, and smoking cessation programs. He said that the IRS is comfortable with these programs so long as they are consistent with the community benefit standard. Mr. Friedlander also said that he is receiving an increasing number of applications and requests from organizations that want to provide alternative medicine services, such as aroma therapies, colonic treatments, or natural food regimens. He explained that the IRS has typically denied exemption to organizations whose activities consist of selling such products to the general public, collecting rents from practitioners of alternative medicine, and advertising alternative medicine services. Exemption may be available, however, for organizations whose purpose is to conduct educational seminars about alternative medicine.

Please contact Miles Hughes with questions at (313) 568-6672 or mhughes@dykema.com.

MICHIGAN HOUSE ACTS ON COMMISSION ON END OF LIFE CARE LEGISLATIVE RECOMMENDATIONS

On October 29 and November 1, 2001, the Michigan House of Representatives acted on a number of bills that had been reported favorably out of the House Health Policy Committee. Some of the bills are consistent with the recommendations of the Michigan Governor’s Commission on End of Life Care, although they are not identical.

Elimination of “Intractable Pain” Terminology

House Bill 5260 amends the controlled substances laws to clarify the ability of physicians to prescribe Schedule 2 drugs for pain management. The current law provides that controlled substances are appropriate for patients with “intractable” pain and that some patients are unable to obtain sufficient Schedule 2 drugs for pain relief. The amendment eliminates the term “intractable” since Schedule 2 drugs often are a drug of choice under current pain management protocols, and because it is rare that properly treated pain is truly intractable. House Bill 5257 also clarifies that patients with “reduced life expectancy

due to advanced illness” are entitled to pain management with Schedule 2 drugs and provides immunity for physicians who hold controlled substances licenses and prescribe in good faith. House Bills 5264 and 5265 also eliminate the term “intractable” and would require health insurers and Blue Cross Blue Shield to provide notice to insureds or subscribers of how their benefits apply in the evaluation and treatment of pain and lists of providers who are board certified in pain management.

Elimination of “Terminal Illness” from Notices Under the Michigan Dignified Death Act

House Bill 5257 changes the trigger point that requires physicians to notify their patients of the availability of hospice, palliative care and pain management. The amendment would require notice whenever a patient has “reduced life expectancy due to advanced illness.” The current law is problematic because it is very difficult for physicians to diagnose when patients with some conditions have a less than six months life expectancy. As a result, many patients are referred to hospice too late to receive maximum benefits. This amendment does not, however, address a major flaw of the current law which suggests that pain management and palliation are inconsistent with curative care.

Replacement of Official Prescription Program with Electronic Monitoring of Prescriptions for Controlled Substances

The most controversial of the bills in the legislative package, House Bill 5260, would replace the Official Prescription Program, that requires a special form for Schedule 2 controlled substances, with electronic monitoring. Under the new scheme, prescriptions for Schedules 2 through 5 would be electronically monitored, as is done currently in some other states. The time for filling Schedule 2 prescriptions would be increased from five days to sixty days, and refills would be allowed if permitted by federal law. As passed, there is a defined format for the content of prescriptions and a requirement for the Department of Consumer and Industry Services to investigate and report on whether prescription forms should be on special paper to reduce fraud. MDCIS would not, however, be able to require special numbering, bar codes or symbols on the forms. Physicians and pharmacies would have access to information to treat current patients, and monitor whether patients are receiving multiple prescriptions. Licensing boards and law enforcement officials would have access in the context of a bona fide investigation of a specific provider or other designated person. House Bill 6262 authorizes electronic signatures and electronic transmission of prescription forms.

The intent of this legislation is to balance availability of controlled substances for pain management with the need for law enforcement. While the current law is over-balanced in favor of law enforcement, the amendments may face challenges in the Senate because of the potential elimination of special forms, and the inability of law enforcement to query the system to spot unusual activity that may indicate drug diversion.

Requirement for Facilities to Provide Information About Hospice and Palliative Care

Hospitals and nursing care facilities would be treated differently under two bills passed by the House. House Bill 5255 would require hospitals to inform requesting parties orally and in writing about the availability of hospice and palliative care services in the institution, and about the availability of hospice care in the service area.

Nursing care facilities would be subject to more burdensome requirements under House Bill 5254 to provide information about the availability of hospice care in the facility in each contract entered into with a patient or guardian or other legal representative, upon expiration of the prior contract and whenever the

source of payment changes. The patient or other responsible person would have to initial the applicable portion of the contract.

Under prior forms of these bills which were not passed, hospitals were subject to the same requirements as nursing care facilities, and noncompliance could allow the patient or other responsible person to declare contracts void. These bills were not included in the recommendations of the Commission on End of Life Care.

Requirements for Drivers License and State Identification Card Information

House Bill 5148 requires the Secretary of State to allow space for an approved form of sticker or decal to be affixed to a driver's license indicating that the patient has designated a patient advocate, has an advance directive, or has an emergency medical information card. House Bill 5266 permits similar information on a state official personal identification card.

For more information about these bills and the next steps in the legislative process, contact J. Kay Felt at (313) 568-6700 or kfelt@dykema.com.

CHECKING FOR EXCLUDED INDIVIDUALS, PART II

In the September issue, we wrote about the penalties for hiring, or retaining as independent contractors, individuals who have been excluded from participation in Medicare, Medicaid or other federal health program.

Since the last issue, the HHS OIG has published Advisory Opinion No. 01-16, posted on October 5, 2001. It deals with the question of whether the employment of an excluded individual by an HMO could constitute grounds for the imposition of administrative sanctions on the HMO. The facts are simple to describe.

The HMO hired a former psychologist as a Senior Program Developer. The psychologist had lost his license and, as a result, had been excluded from participation in Medicare and other federal health programs. His position with the HMO involved training employees in various human resources areas having nothing to do with the employees' medical or administrative skills. He had no contact with the HMO's membership and was not involved in the delivery of health care services or any aspect of billing.

The Advisory Opinion noted the general rule that a provider that receives federal health care program funding may only employ excluded individuals in situations where the provider pays all costs associated with the employee with non-federal funds and where the employee furnishes no services to federal programs or patients. Based on that rule, the Advisory Opinion framed the issue this way: Are the services furnished by the former psychologist "sufficiently attenuated" from the federal aspects of the program so that the costs associated with such services are outside the scope of the services the federal programs are intended to cover?

The Opinion's conclusion was that employee training is an integral part of the operation of an HMO involved in the Medicare+Choice program, and that, therefore, the costs associated with his work represent part of the administrative costs reported to CMS. Notwithstanding this conclusion, the Opinion finally determined that the employee's duties were "so far removed from the actual provision of items and services to program beneficiaries....andare not an ordinary or necessary component of providing items and services to beneficiaries and are not the subject of any identifiable Federal funding or regulatory mandates," that his employment presented minimal risks and would not subject the HMO to sanctions.

What lesson can we learn from this Advisory Opinion? Certainly, the principal conclusion is that any provider must be very careful before hiring or retaining someone who is excluded. If the psychologist at issue in the Advisory Opinion was such a close case, then prudence would dictate a thorough review of the situation before hiring or retaining any excluded person, regardless of the position they are to occupy. If there is good news in this Advisory Opinion, it is that there may be isolated positions where such an individual could be hired or retained. Whether your organization wishes to take the risk without an advisory opinion is the question.

In our October newsletter, we provided web site addresses for you to check as part of the hiring/retention process, and periodically thereafter. Unfortunately, the web sites mentioned turned out to be difficult to use. We now recommend the following sites: (1) for the OIG website, use www.os.dhhs.gov/oig/cusman/index.htm, or for direct access to the site, use <http://exclusions.oig.hhs.gov/home.htm/>; (2) for the GSA website, use <http://www.arnet.gov/epl/>. We regret any difficulty you may have had.

Please contact Seth Lloyd for further information at (313) 568-6837 or slloyd@dykema.com.



Dykema Gossett Health Care Practice Group

Maria B. Abrahamsen
Phyllis Donaldson-Adams
J. Kay Felt
Jane Forbes
Miles W. Hughes

Kathrin E. Kudner
Joanne R. Lax
Seth M. Lloyd
Monica R. Matter
Thomas J. McGraw
Kathleen A. Reed

Offices

Ann Arbor
Bloomfield Hills
Chicago
Detroit
Grand Rapids
Lansing
Washington, D.C.
Telephone:(313) 568-6800
Fax:(313) 568-6991
Website: www.dykema.com

©2001 Dykema Gossett PLLC

As part of our service to you, we regularly compile short reports on new and interesting developments in health law and the issues the developments raise. You should recognize, of course, that these reports do not constitute legal advice and that we do not attempt to cover all such developments. Your comments on Health Law Developments are always welcome.
